

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1700

## CERTIFICATE OF DEATH

01703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION TOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LYDIA MAUDE ALBAUGH</u>		4. DATE OF DEATH <u>FEB. 17</u> 19 <u>59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 23 - 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EZRA NUSBAUM</u>		14. MOTHER'S MAIDEN NAME <u>MARY RIDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS RUSSELL HOOVER</u>		Address <u>RURAL, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>58</u> , to <u>Feb 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>59</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Caricofe</u>		ADDRESS (Street, city or town, state) <u>M.D. 118 South 6 Main, Union Bridge, Md</u>	
PHYSICIAN'S NAME (Type) <u>Joseph H. Caricofe</u>		DATE SIGNED <u>Feb 18 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>		22d. LOCATION (City, town, or county) <u>CARROLL COUNTY, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartley &amp; Sons, Union Bridge Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 20 '59</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1907

WILLIAM

EDMOND

WILLIAM

EDMOND

WILLIAM

EDMOND

WILLIAM

EDMOND

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EDMOND

WILLIAM

EDMOND

WILLIAM

EDMOND

WILLIAM

1701

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6mo. 6 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>St. James Hotel</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last <b>Estelle Durham Armstrong</b>	
4. DATE OF DEATH Month Day Year <b>February 19 1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 20, 1880</b>	
9. AGE (In years last birthday) <b>78 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Columbus Durham</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Reichstine</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-09-2901D</b>		17. INFORMANT <b>Springfield Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422.1</b> (c) <b>years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <b>assoc. with cerebral arteriosclerosis, with psychotic reaction.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>BALTO</b>		20g. (County) <b>MD.</b>		20h. (State) <b>MD.</b>		21. I certify that I attended the deceased from <b>8/13</b> 19 <b>58</b> to <b>2/19</b> 19 <b>59</b> that I last saw the deceased alive on <b>2/19</b> 19 <b>59</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>YVES H BOENNEC</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK CEM.</b>		22d. LOCATION (City, town, or county) <b>BALTO</b>		22e. (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jane M. Saffell</b>		23a. ADDRESS <b>258 E. Main St. Westminster Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 24 59</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Harris</b>		24c. DATE <b>FEB 24 59</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

223

Reported by: [illegible]

Address: [illegible]

Age: [illegible]

Sex: [illegible]

Color: [illegible]

1/2

1/2

1/2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1702

CERTIFICATE OF DEATH

01705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1mo. 14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Simpson</b> Last <b>Belsinger</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 17, 1884</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b> Hours <b>4</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jacob Belsinger</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Simon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>1902 to 1905 212-09-1831</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 22, 1958</b> to <b>February 6, 1959</b> , that I last saw the deceased alive on <b>February 5, 1959</b> , and that death occurred at <b>6:02A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>2/6/59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				<b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 9. 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>				ADDRESS <b>Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1703

## CERTIFICATE OF DEATH

017066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>				c. LENGTH OF STAY IN 1b <u>11 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>John</u> Last <u>Berg</u>				4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-96</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>Lewis Berg</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 5-31-18 to 4-24-20</u>				16. SOCIAL SECURITY NO. <u>215-03-8736</u>		17. INFORMANT <u>Records Springfield State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>							
20c. TIME OF INJURY Hour <u>9</u> m. <u>30</u> p. m. <u>  </u> Day <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>March 19</u> , 19 <u>58</u> , to <u>Feb. 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 19</u> , 19 <u>59</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2-19-1959</u> ACTUAL SIGNATURE <u>Walter Knopp</u> M.D. PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u> <u>Sykesville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb 23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Balair Road</u>				24a. REC'D BY REGISTRAR <u>FEB 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

MARRIAGE

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS



## 1704 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>46 y 3 m 7 d</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Md</b>				d. STREET ADDRESS <b>Springfield State Hospital</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Christian</b> Middle <b>F.</b> Last <b>Berry</b>				4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-13-89</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>23</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>69</b> Days <b>23</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Apprentice printer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland - Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>August Perry</b>				14. MOTHER'S MAIDEN NAME <b>Barbara KIMBLE Volz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>S.S. Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) <b>Epileptic psychosis. Bronchopneumonia.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years.</b> <b>years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epileptic psychosis. Bronchopneumonia.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield State Hospital</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>March 2-22 - 1959</b> to <b>Febr. 22, 1959</b> , that I last saw the deceased alive on <b>2-22 - 1959</b> , and that death occurred at <b>5:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin Del Campo</b> M.D.				DATE SIGNED <b>2-23-59</b>			
PHYSICIAN'S NAME (Type) <b>Agustin Del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>				22e. (State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckner &amp; Sons</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William J. Tuckner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1705

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WATTEN</u> First <u>W. BLIZZARD</u> Middle <u>D.</u> Last		4. DATE OF DEATH <u>Feb 17</u> 19 <u>59</u> Month <u>Feb</u> Day <u>17</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11, 1923</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chapman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Storm Windows</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Blizzard</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Hipley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Anna Blizzard</u> Address <u>Sykesville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial, Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Aug 17 58</u>	
420.1 DUE TO		b. DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		c. DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 17 58</u> , 19 <u>58</u> , to <u>Feb 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>59</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hank</u> M.D.		DATE SIGNED <u>Feb 17 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HANK</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Haight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1706

## CERTIFICATE OF DEATH

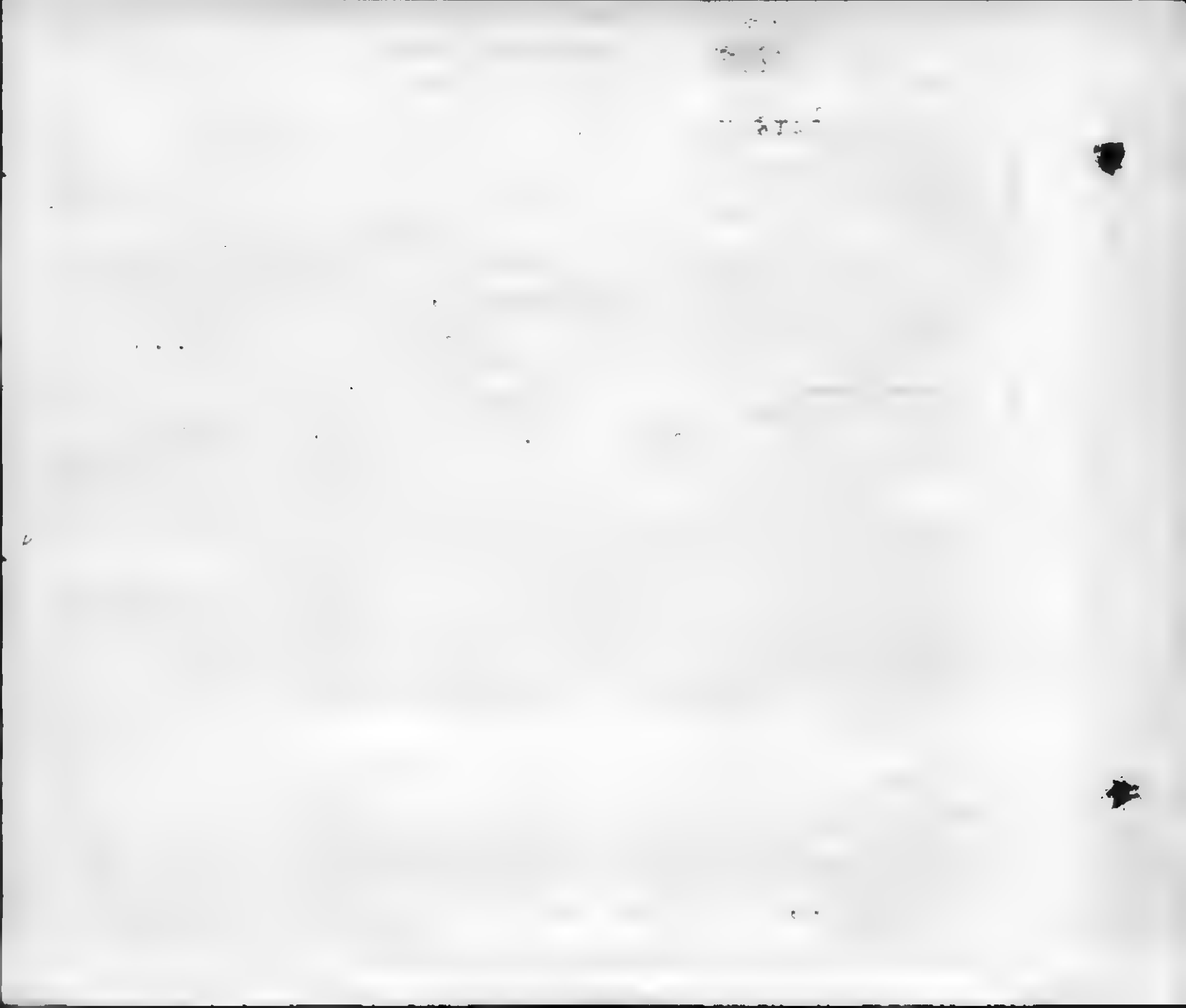
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Lulu</b> Middle <b>B</b> Last <b>Brower</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 8, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Warren Brower</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Saylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Paul Brower, Taneytown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>7 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1957</b> , to <b>Feb. 2, 1959</b> , that I last saw the deceased alive on <b>Feb 1, 1959</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2-2-59</b>			
ACTUAL SIGNATURE <b>James J. Marsh</b> M.D.		PHYSICIAN'S NAME (Type) <b>JAMES T MARSH</b> <b>Wheaton</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 4, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>C.O. Fuss &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 4 '59</b>	
ADDRESS <b>Taneytown, Maryland</b>		24b. REG STRAR'S SIGNATURE <b>Colbert S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1707

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lyskensville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lyskensville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>JASPER</u> First <u>Bullock</u> Middle Last		4. DATE OF DEATH <u>Feb</u> Month <u>5</u> Day Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Bullock</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Bullock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>213-18-8857</u>	
17. INFORMANT <u>Maria Bullock Lyskensville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>440.1</u> DUE TO <u>CORONARY THROMBOSIS, Hypertension,</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage, ARTERIOSCLEROSIS</u> (c) <u>Generalized, Anemia,</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>70</u> <u>5 Feb 59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>5 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5 Feb</u> , 19 <u>59</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Lyskensville, Md</u> DATE SIGNED <u>5 Feb 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/7/59</u>	<u>White Rock</u>	<u>White Rock Rd. Carroll &amp; Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Wright Lyskensville, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>FEB 11 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis A. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1708  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>8mos. 15days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Belle</b> Last <b>Johnson Burriss</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1879</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>79</b>	IF UNDER 24 HRS. Days <b>79</b> Hours <b>79</b> Min <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Smith Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Octavia Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.E.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 17, 1958</b> , to <b>February 2, 1959</b> , that I last saw the deceased alive on <b>February 2, 1959</b> , and that death occurred at <b>9:20A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>2/2/59</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) <b>Sykesville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur H. Haight</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1709

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>34yrs. 10mos. 13days</b>		d. STREET ADDRESS <b>1204 S. Charles Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>L.</b> Last <b>(Miller) BYRNES</b>		4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Miller</b>		14. MOTHER'S MAIDEN NAME <b>Mary Daley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	

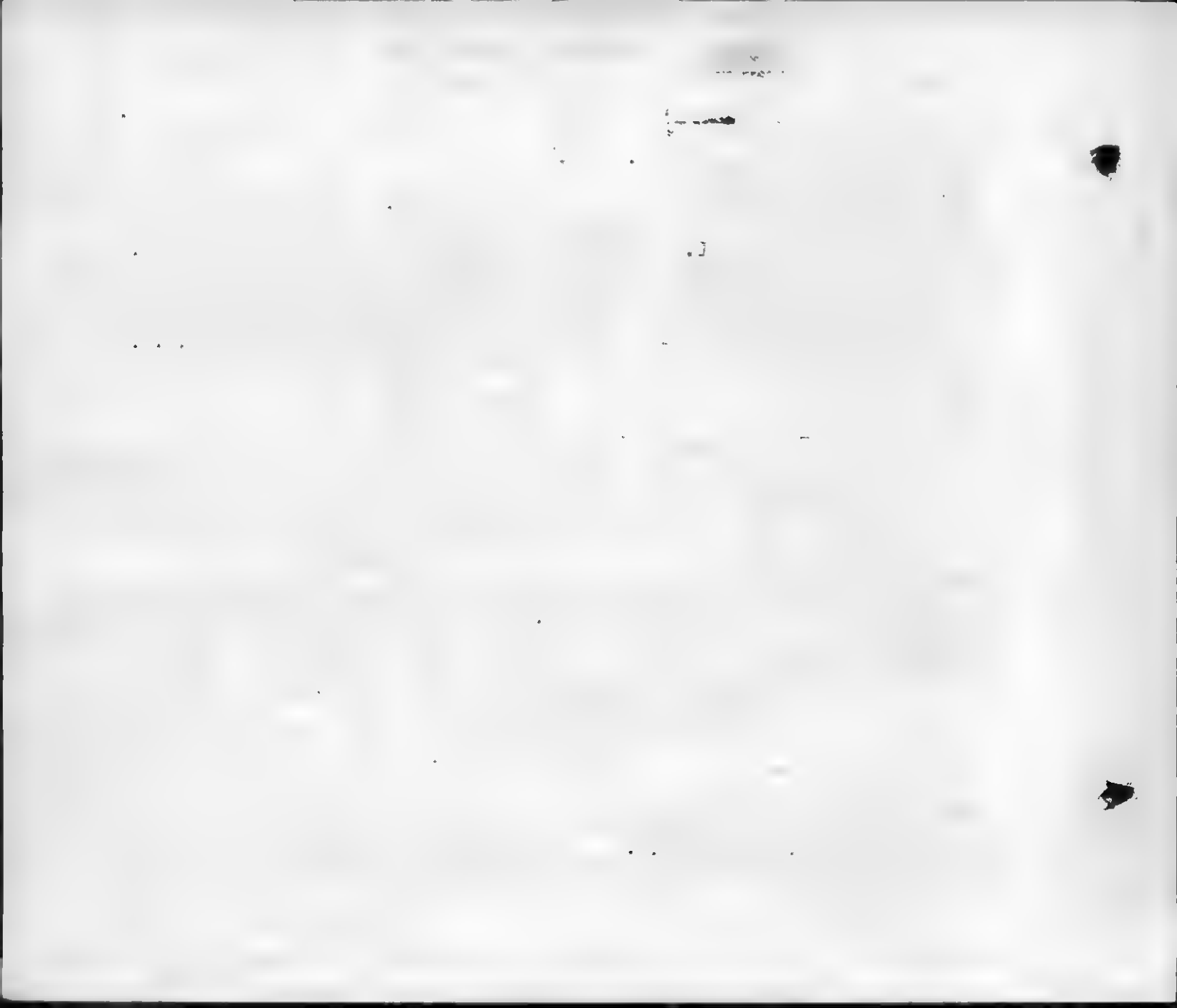
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>August 5, 1958</b> , to <b>February 26, 1959</b> , that I last saw the deceased alive on <b>February 26, 1959</b> , and that death occurred at <b>9:25A</b> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Yves H. Boennec</b> M.D.	ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>2/26/59</b>
PHYSICIAN'S NAME (Type) <b>Yves H. Boennec, M.D.</b> <b>Sykesville, Maryland</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery Baltimore Md.</b>	22d. LOCATION (City, town or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles F. Will</b>		24a. REC'D BY REGISTRAR <b>FEB 27 '59</b>	
ADDRESS <b>100 E. Fort Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Charles F. Will</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01713

1710

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLIE ALVERTA CARTZENDAFNER</u>				4. DATE OF DEATH Month Day Year <u>FEB 22 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 14 - 1880</u>	9. AGE (In years last birthday) yrs <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES W FRITZ</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE KAUFFMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>CHARLES CARTZENDAFNER</u>		Address <u>MD NEW WINDSOR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous - original site - Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>5/20/58</u> , 19____, to <u>2/22/59</u> , 19____, that I last saw the deceased alive on <u>2/22/59</u> , 19____, and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.				ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>2/22/59</u>			
PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>				<u>NEW WINDSOR MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hartley &amp; Sons</u>				ADDRESS <u>New Windsor Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Meadow View Conv. Home</u>		d. STREET ADDRESS <u>Willie St Court Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>-</u> Last <u>CASE</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done. If no most of working life, even if retired) <u>retired bricklayer &amp; contractor (self)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry A. Case</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Beaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Miss Margaret L. Case Westminster Md</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma pharynx-</u> <u>160.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma nose</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>41</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General a.s.c.v disease - trace. ph. lipo</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958, to Feb. 15, 1959</u> , that I last saw the deceased alive on <u>Feb 14, 1959</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2-16-59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		<u>Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John's Catholic Center</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Myers Jr, Westminster, Md</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>FEB 18 '59</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

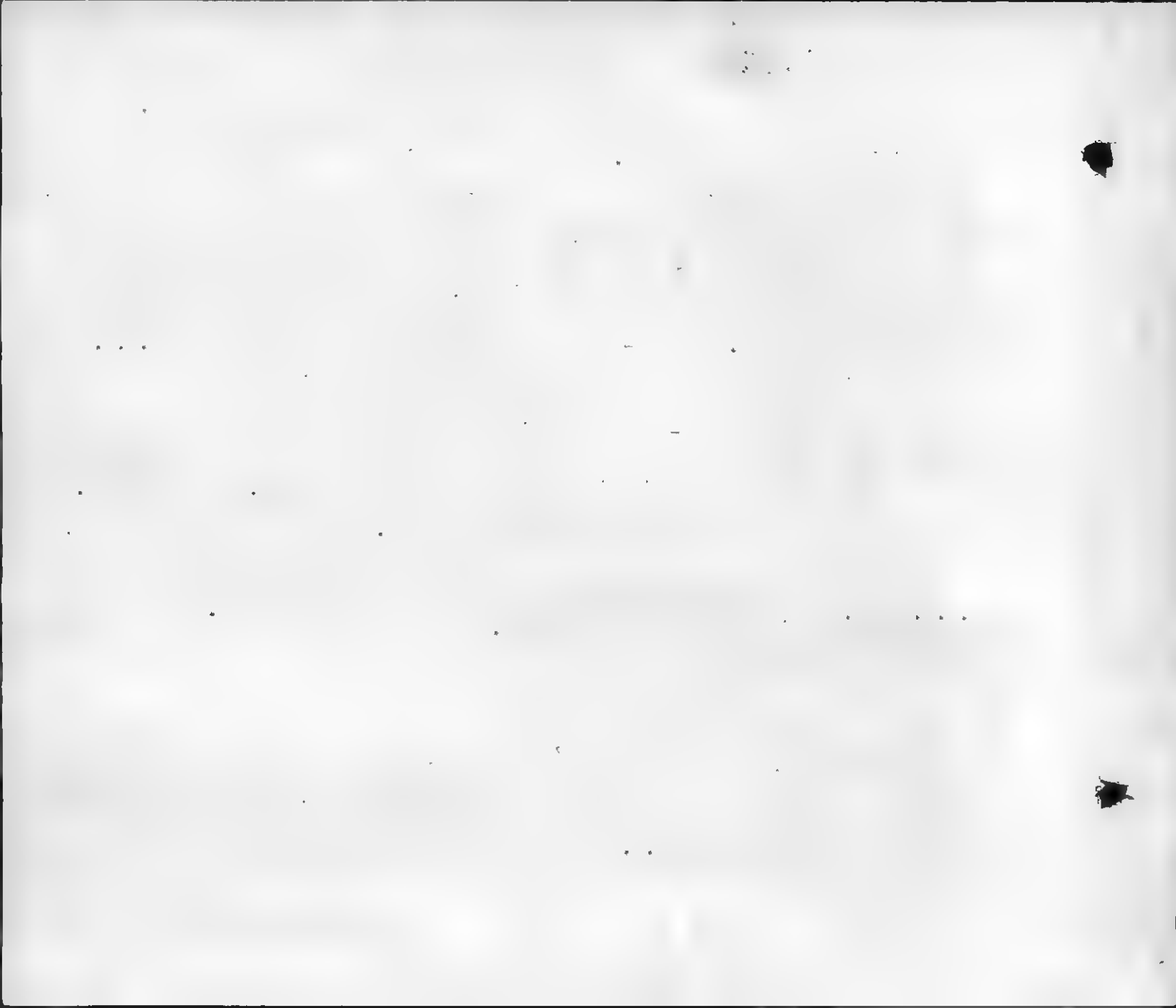
01715

1712

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN IB <b>6mos. 26days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1825 McKim Court</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Randolph</b> Last <b>Conner</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1894</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motion picture operator.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Oliver Conner</b>				14. MOTHER'S MAIDEN NAME <b>Florence Cora Lilly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes: 1st world war</b>				16. SOCIAL SECURITY NO. <b>212-01-6033</b>			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease.</b>							<b>Years.</b>
DUE TO (b) <b>Generalized arteriosclerosis.</b>							<b>Years.</b>
DUE TO (c) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral bronchopneumonia.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>July 18, 1958</b> to <b>February 14, 1959</b> that I last saw the deceased alive on <b>February 13, 1959</b> and that death occurred at <b>4:10A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>			
DATE SIGNED <b>2/15/59</b>							
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2-19-59</b>		<b>Baltimore National</b>		<b>Calonsville 28 Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>G. S. S.</b>			



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor R.D.</u>				c. LENGTH OF STAY IN b. <u>5 MO.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Winfield</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLIFTON JAMES COOK</u>				4. DATE OF DEATH Month Day Year <u>FEB. 3 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1875</u>	9. AGE (In years last birthday) yrs <u>83</u>	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Reuben Cook</u>			
14. MOTHER'S MAIDEN NAME <u>Eliza London</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Mr. Milton W. Cook, Westminister, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>A.S.C.V. disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>— years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb - 2</u> , 19 <u>59</u> to <u>Feb 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 3</u> , 19 <u>59</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2-4-59</u>							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.				PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u> <u>Westminister Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 6, 59</u>		<u>Stone Chapel Cemetery</u>		<u>Rural New Windsor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Marsh, Westminister, Md.</u>				24a. RECD BY REGISTRAR DATE <u>FEB 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino S. Kane</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

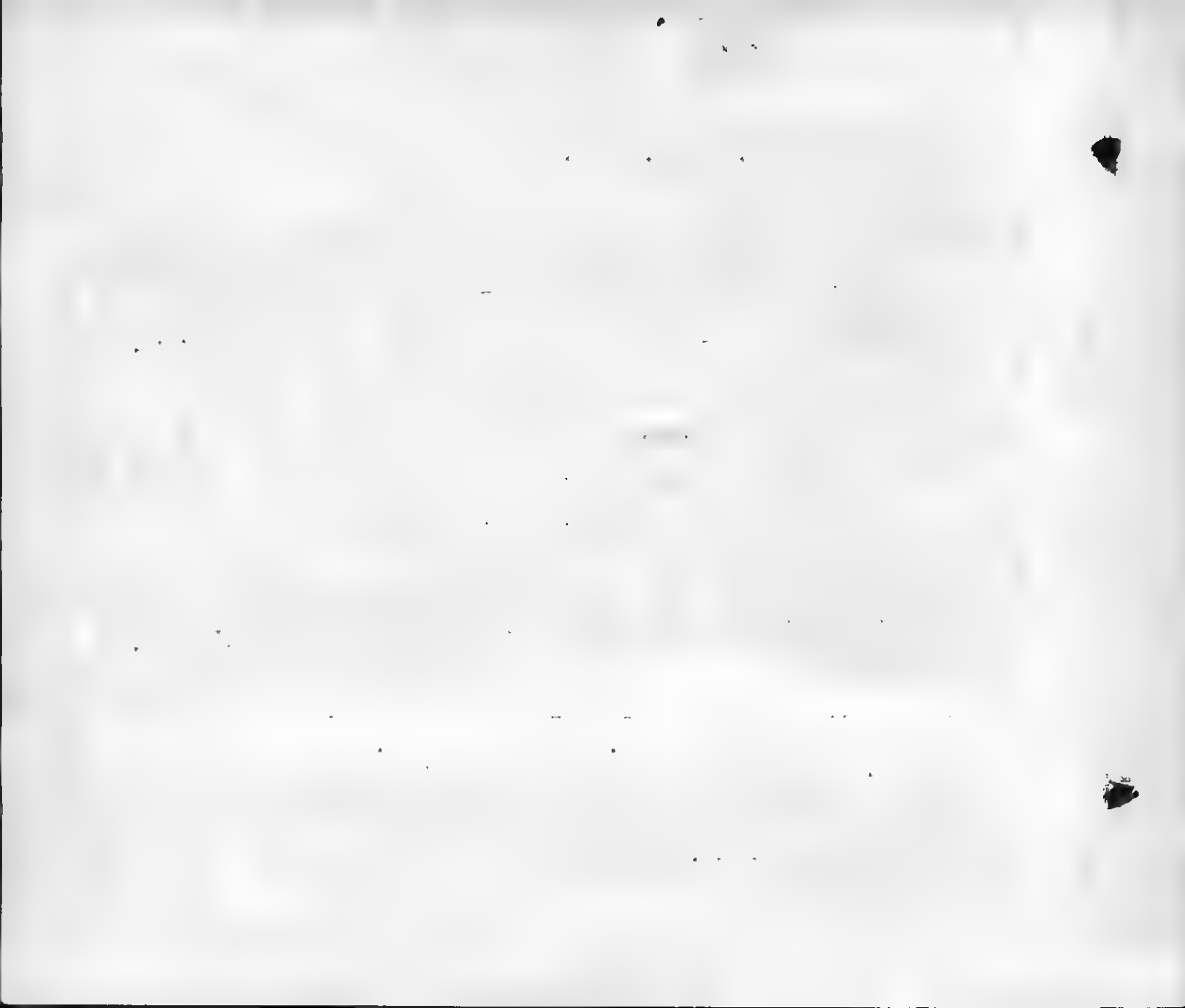
1714

## CERTIFICATE OF DEATH

01717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville, Md.</b>		c. LENGTH OF STAY in 1b <b>11 Mo. 7 days.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>309 Fridinger Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>Cridler</b>		4. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-?</b>
9. AGE (In years last birthday) yrs. <b>86-?</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horse Trainer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- Ynk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cridler</b>		14. MOTHER'S MAIDEN NAME <b>Ellie Eastner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1917-1918 218-30-7859</b>	
17. INFORMANT <b>Records Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Diabetes.</b>	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 26</b> , 19 <b>58</b> , to <b>Feb. 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb. 3</b> , 19 <b>59</b> , and that death occurred at <b>5:40 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-3-1959</b>			
ACTUAL SIGNATURE <b>Walter Knopp</b> M.D.		PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frederick</b>		22d. LOCATION (City, town, or county) (State) <b>Edwardsburg, Carroll Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Hight Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur H. Hight</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

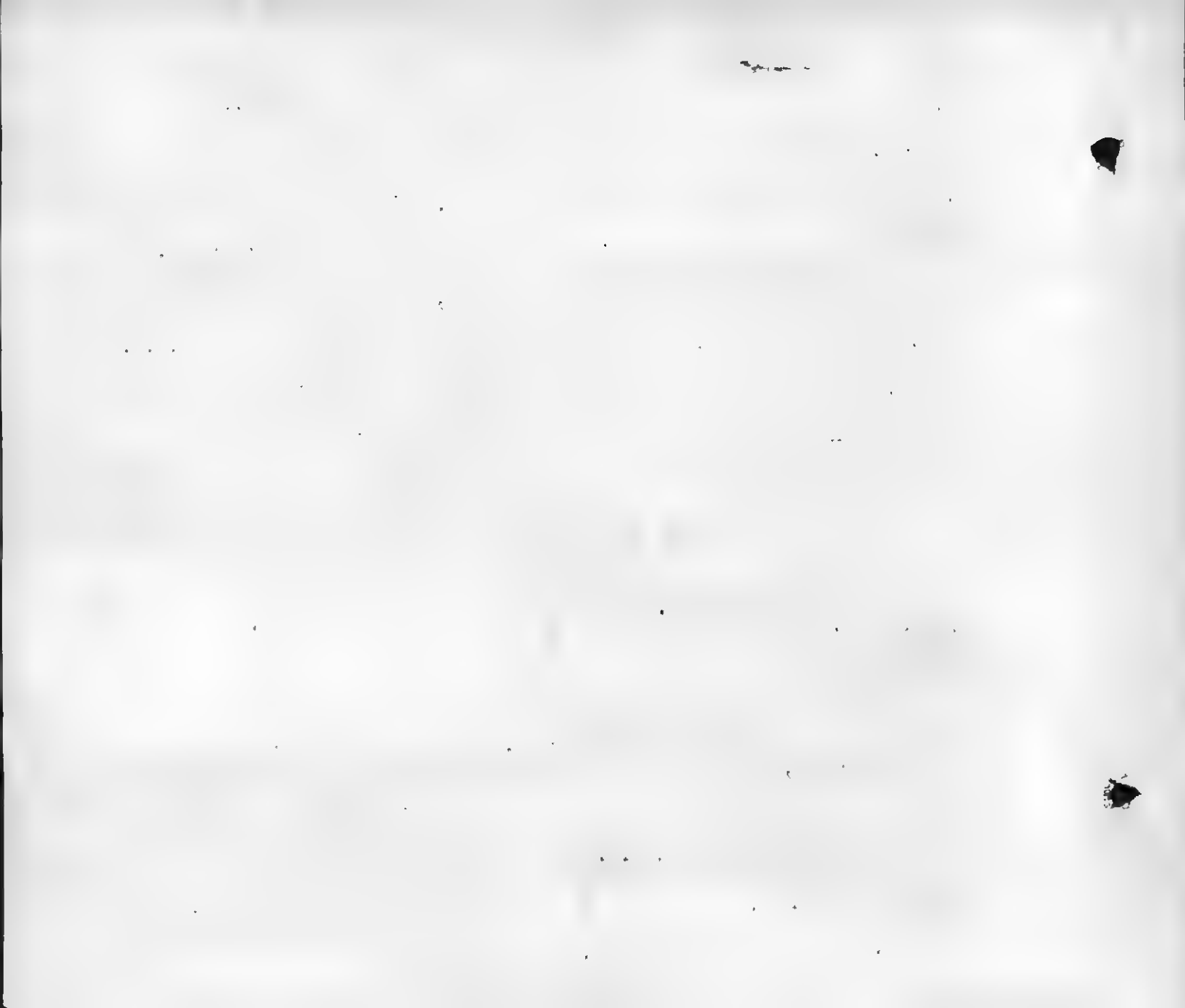
1715

## CERTIFICATE OF DEATH

Reg. Dist. No.

01715

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>Westminster</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Benjamin Darms</b>				4. DATE OF DEATH Month Day Year <b>February 25, 1959</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1874</b>	9. AGE (In years last birthday) yrs. <b>84</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Darms</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Weismiller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no -</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cellulitis of the left hand. C.B.S. assoc. with senile brain disease with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH Years Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>December 19, 1959</b> , to <b>February 25, 1959</b> , that I last saw the deceased alive on <b>February 24, 1959</b> , and that death occurred at <b>6:30 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 2/25/59</b>							
ACTUAL SIGNATURE <b>Agustini del Campo</b>		M.D. <b>Springfield State Hospital</b>					
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Stevens Point, Wisconsin</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>				ADDRESS <b>Westminster, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 2 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. W. S. R. and</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

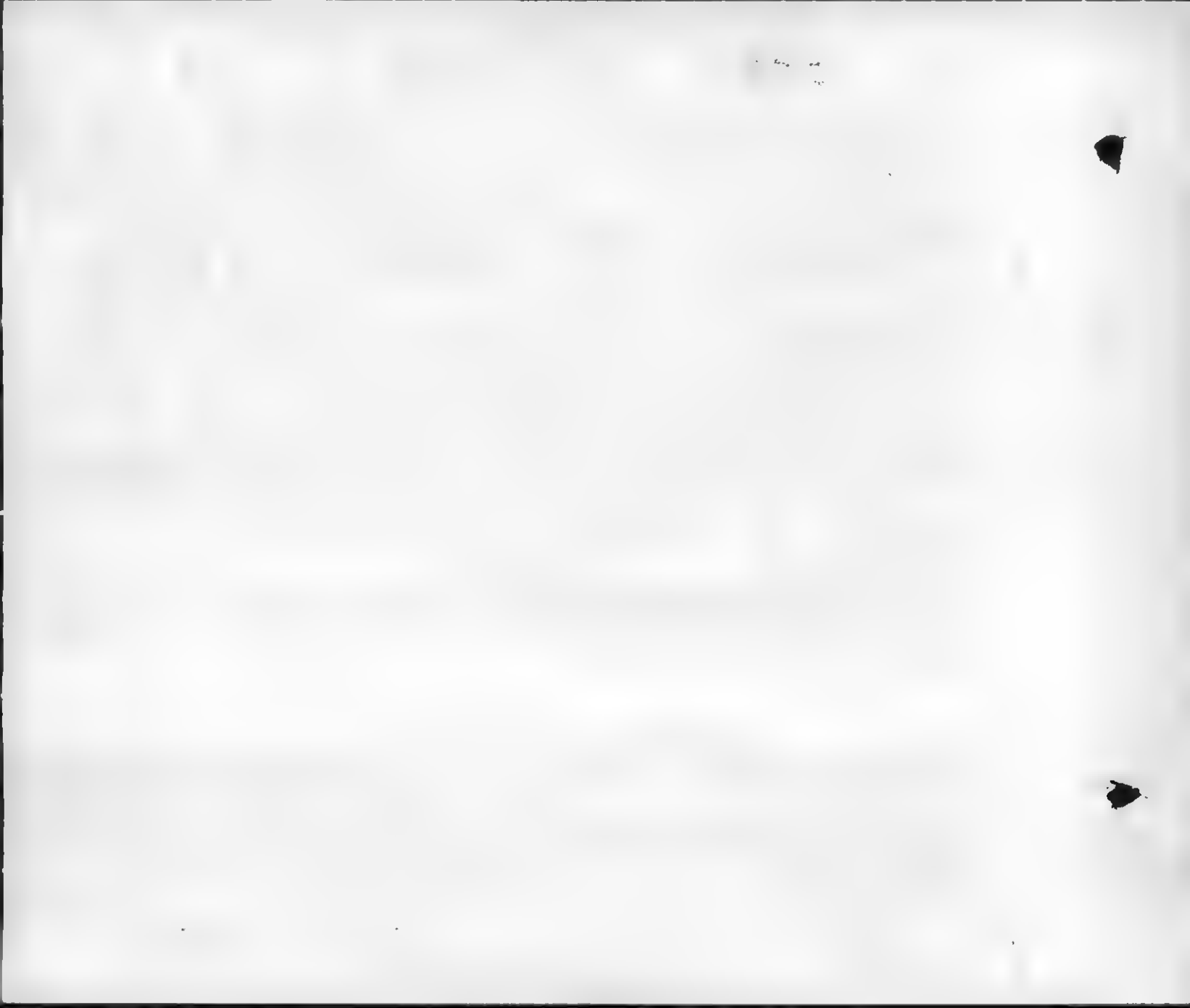
1716  
CERTIFICATE OF DEATH

Reg. Dist. No.

01719

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINWOOD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINWOOD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		d. STREET ADDRESS <u>RURAL</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TRUMAN JOSEPH DAYHOFF</u>		4. DATE OF DEATH Month Day Year <u>FEB 27 19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/1911</u>
9. AGE (In years last birthday) yrs. <u>47</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPER.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>CORDAGE MFG</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOSEPH OLIVER DAYHOFF</u>	
14. MOTHER'S MAIDEN NAME <u>ANNIE SKIMMER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>214-12-9633</u>		17. INFORMANT <u>THELMA J. DAYHOFF, LINWOOD, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19____, to <u>2/27/59</u> , that I last saw the deceased alive on <u>2/24/59</u> , 19____, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>New Windsor, Md. 2/27/59</u>	
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>		<u>NEW WINDSOR MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>BURIAL</u>	<u>3/1/59</u>	<u>PIPE CREEK</u>	<u>CARROLL COUNTY MD</u>
FUNDING DIRECTOR'S SIGNATURE <u>D. D. Hartley (Hans)</u>		ADDRESS <u>New Windsor, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01720

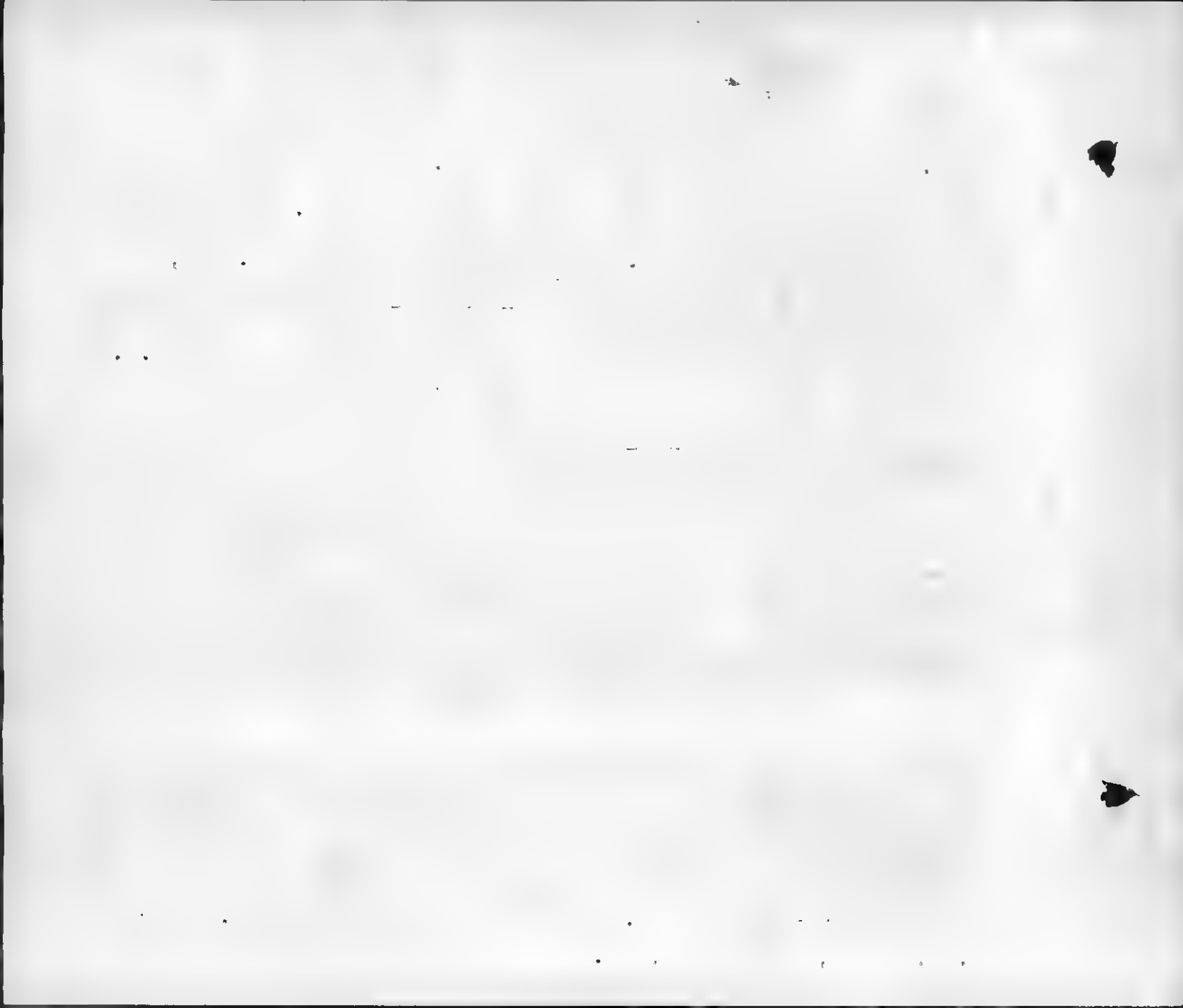
1717

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
c. LENGTH OF STAY IN 1b <b>Life</b>		d. STREET ADDRESS <b>Twin Arch Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLAUDE A. DOTSON</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2,</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-1922-?</b>
9. AGE (In years last birthday) <b>36</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>general</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward Dotson</b>		14. MOTHER'S MAIDEN NAME <b>Effie Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-32-4412</b>	
17. INFORMANT <b>Mrs. Evelyn Croft</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2/2/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-5-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 4 '59</b>	
<b>Winfield, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

Item 11 Film 299 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 01721									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		1718		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>		c. LENGTH OF STAY IN 1b <u>12 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENT ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BARBARA</u>		First <u>L</u> Middle <u>D</u> Last <u>LANEY</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1959</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7-1925</u>		9. AGE (in years last birthday) <u>33</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gun home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Irvin Murray</u>		14. MOTHER'S MAIDEN NAME <u>Louise Kille</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>		17. INFORMANT <u>great daughter, Manchester, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sustained</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Gunshot to head</u>							
20c. TIME OF INJURY Month, Day, Year <u>7:55</u> <u>2-27</u> <u>1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Melrose-Manchester Corner Md</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James J. Marsh</u>		EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/27/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-2-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw &amp; Gipton Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>DATE 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1719

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Arthur &amp; Oakland Hds.</u>	
3 NAME OF DECEASED (Type or print) <u>John Howard EDMONDSON</u>		4. DATE OF DEATH <u>Feb. 13</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1958</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 24 HRS. Months <u>2</u> Days <u>23</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis C. Edmondson</u>		14. MOTHER'S MAIDEN NAME <u>Sharon Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Louis Edmondson</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonia</u>			
490x DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Marsh</u>		DATE SIGNED <u>2/13/59</u>	
EXAMINER'S NAME <u>JAMES T. MARSH</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive</u>	22d. LOCATION (City, town or county) (State) <u>Randallstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Hight</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '59</u> 24b. REGISTRAR'S SIGNATURE <u>ue</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1720

## CERTIFICATE OF DEATH

01723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>MAIN ST</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>MAE</u> Last <u>ELINE</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20-1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours M n			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER AT home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD BRIGHTWELL</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN WILSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>NONE</u>			
17. INFORMANT <u>MRS KATHRYN HARTZLER</u> Address <u>Union Bridge Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-13-</u> , 19 <u>59</u> , to <u>2-4-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-3-</u> , 19 <u>59</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> DATE SIGNED <u>2-5-59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. T. H. Legg</u>				<u>Union Bridge, Maryland</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2/7/59</u>		<u>DEER PARK CEM</u>		<u>DEER PARK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hartzler &amp; Sons, Union Bridge Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. H. H. H.</u>	



1721

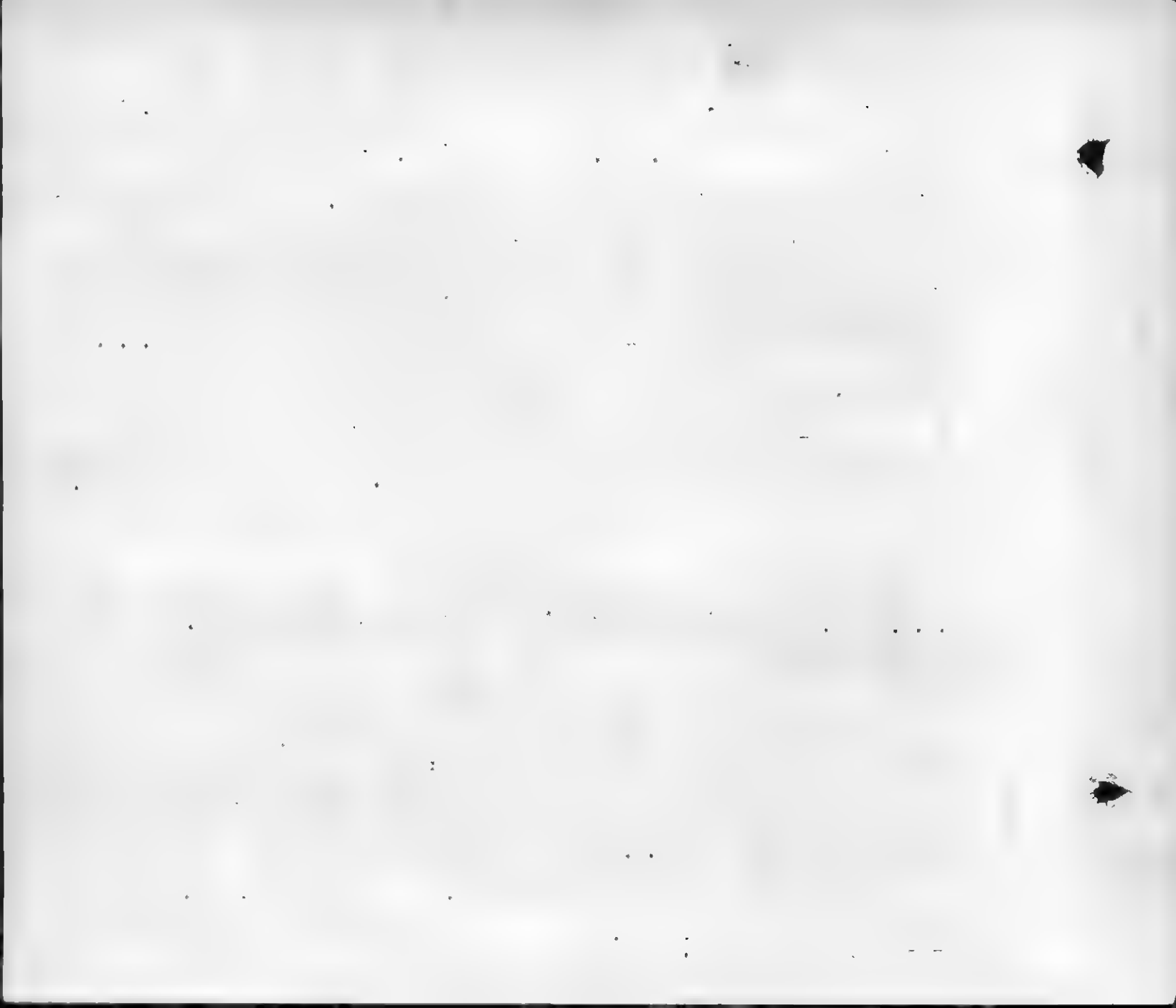
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1yr. 5mos. 26days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>916 N. Duncan Street</b>			
				d. STREET ADDRESS <b>Baltimore 24.</b>			
3. NAME OF DECEASED (Type or print) First <b>Nicholas</b> Middle <b>John</b> Last <b>Ellinghaus</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1876</b>		9. AGE (In years last birthday) <b>82</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stemfitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas E. Ellinghaus</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Lord</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis, far advanced.</b> <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 21, 19 57</b> , to <b>February 17, 19 59</b> , that I last saw the deceased alive on <b>February 16, 19 59</b> , and that death occurred at <b>4:50A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>2/17/59</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b> <b>2601-3-5 E. Madison St.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 18 59</b>		24b. REGISTRAR'S SIGNATURE <i>William A. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

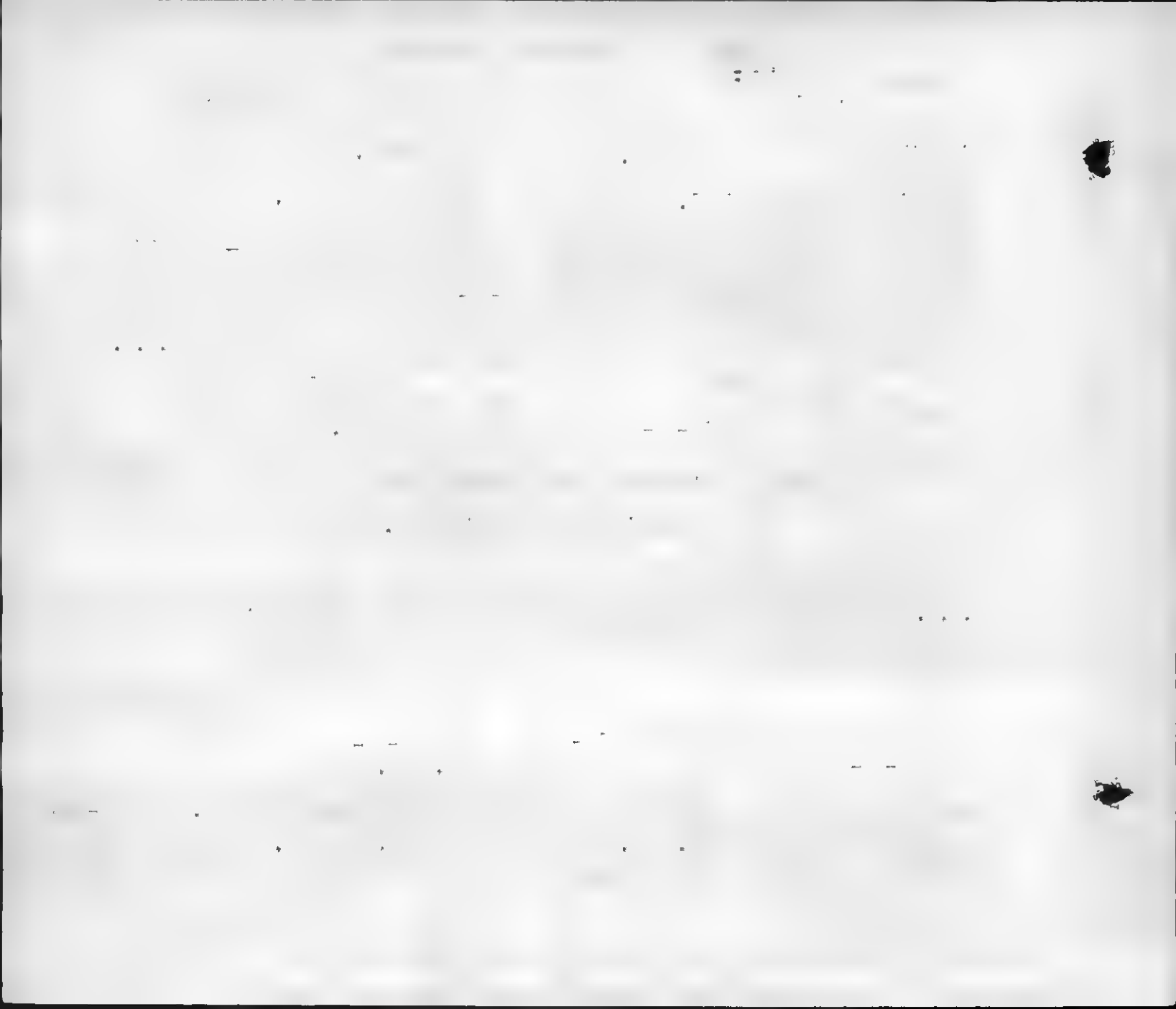
1722

## CERTIFICATE OF DEATH

Reg. Dist. No.

01725

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 30</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>2mths. 4days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>				d. STREET ADDRESS <b>4619 Frankford Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Adda</b> Last <b>Fallon</b>				4. DATE OF DEATH Month <b>2-</b> Day <b>15</b> Year <b>19 59</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-10-1868</b>		9. AGE (In years last birthday) yrs <b>90</b>	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleswoman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Fallon</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Shill</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>212-16-9925</b>		17. INFORMANT <b>Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							<b>years</b>
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Generalized arteriosclerosis.</b>							<b>years</b>
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>C.B.S. associated with senile brain disease, with psychotic reaction</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-11</b> , 19 <b>58</b> , to <b>2-15-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-15-</b> , 19 <b>59</b> , and that death occurred at <b>1.30 A.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				<b>Springfield State Hospital.</b>		<b>2-15-59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				<b>Sykesville, Maryland.</b>			
22a BURIAL, CREMATION, REMOVAL (Specify)		22b DATE THEREOF <b>2/18/59</b>		22c NAME OF CEMETERY OR CREMATORY <b>New Catholic</b>		22d LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Samuel J. Kuck</b>				ADDRESS <b>5305 Hayford Rd</b>		24a REC'D BY REGISTRAR <b>FEB 17 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>2 Kuma</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1723

01726

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>Taneytown</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Hilda</b> Last <b>Feeser</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore Feeser</b>		14. MOTHER'S MAIDEN NAME <b>Mary Emma Harman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mr. Russell Feeser, Taneytown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Congestive Heart failure</b> DUE TO (c) <b>Valvular Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 mo</b> <b>50 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			19. WAY AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 1952</b> to <b>Feb 13 1959</b> , that I last saw the deceased alive on <b>Feb 13 1959</b> , and that death occurred at <b>7:42 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Frederick St., Taneytown, Md.</b> DATE SIGNED <b>2/13/59</b>			
ACTUAL SIGNATURE <b>E. Ambler Thompson</b> M.D. <b>49 Frederick St., Taneytown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson, M.D. 49 Frederick St., Taneytown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 15, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>	24a. REC'D BY REGISTRAR <b>FEB 16 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Carroll S. Kraw</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

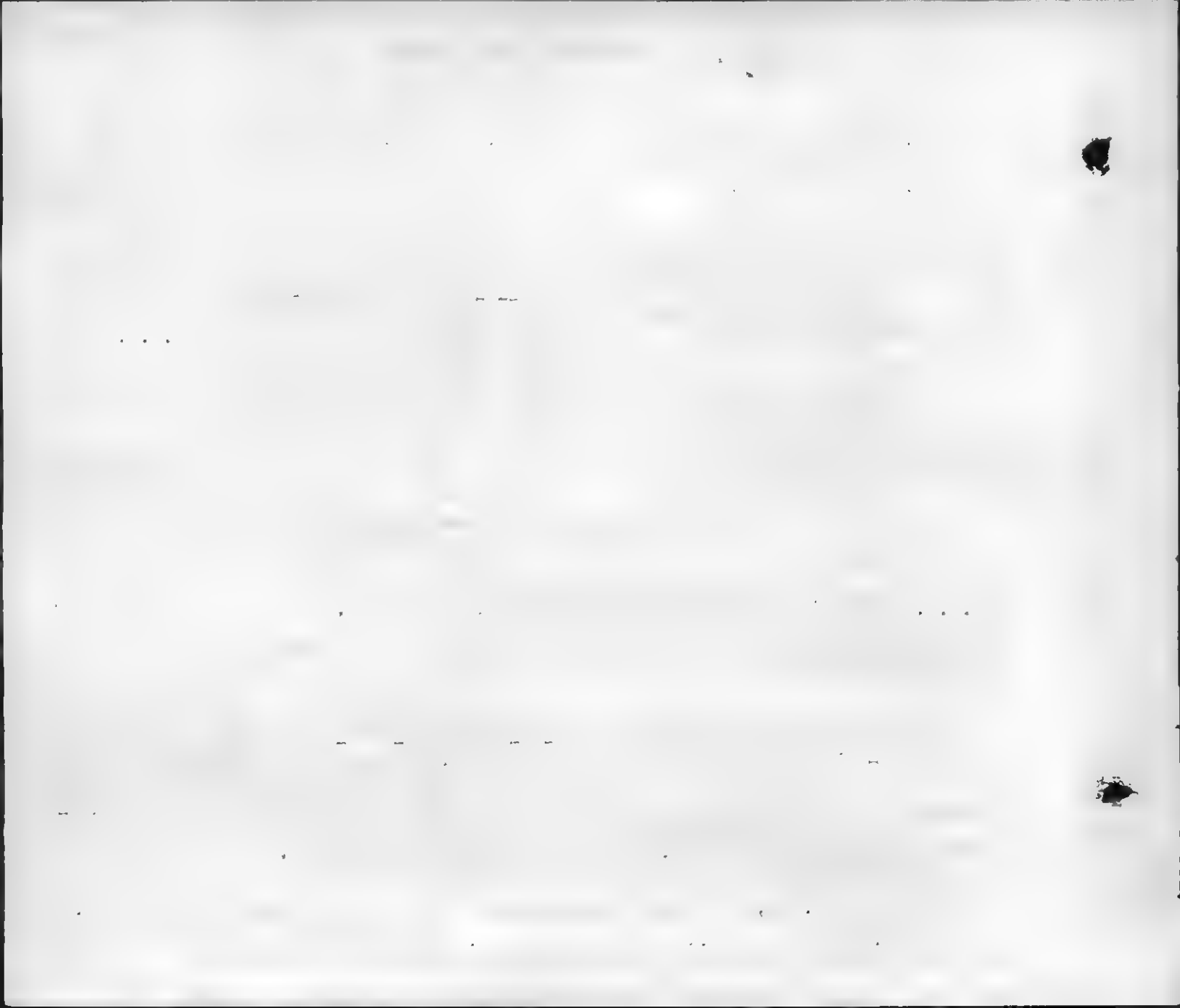
Reg. Dist. No.

01727

1724

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Luther</b> Middle <b>Benton</b> Last <b>Fete</b>		4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 4, 1875</b>
9. AGE (In years last birthday) <b>83 84 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>printer and Physiotherapist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benton Fete</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unkn NO</b>		16. SOCIAL SECURITY NO <b>NONE unk</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> <b>422.1</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc with cerebral arteriosclerosis, with psych. reaction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-20-1959</b> to <b>2-22-1959</b> that I last saw the deceased alive on <b>2-21-1959</b> and that death occurred on <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-22-59</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> <b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 24, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Prince George's County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc., Silver Spring, Md.</b> <b>Raymond C. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 59</b>	24b. REGISTRAR'S SIGNATURE <b>Raymond C. Ziska</b>

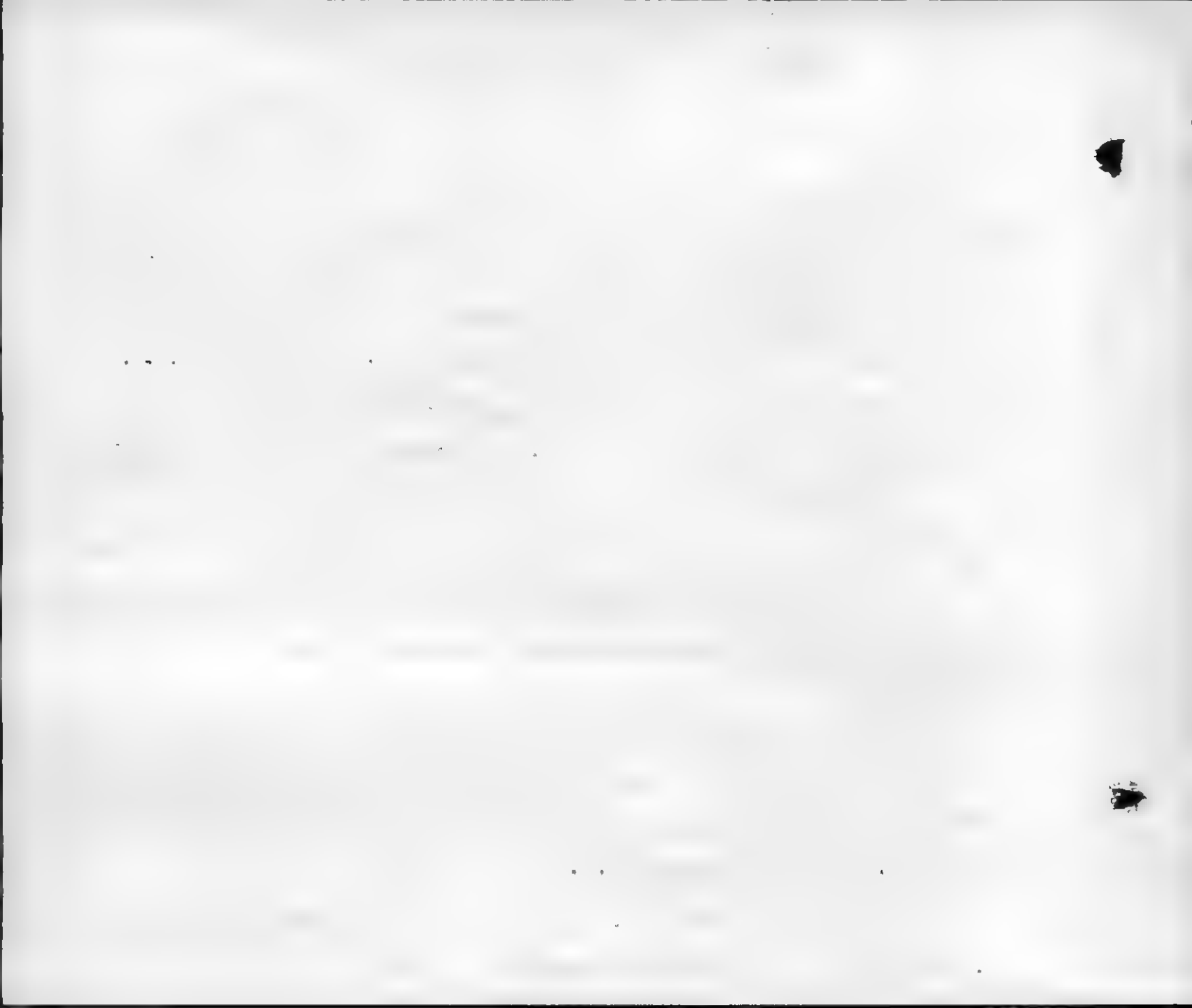
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 01728

1725

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ISM 10/S7





1726

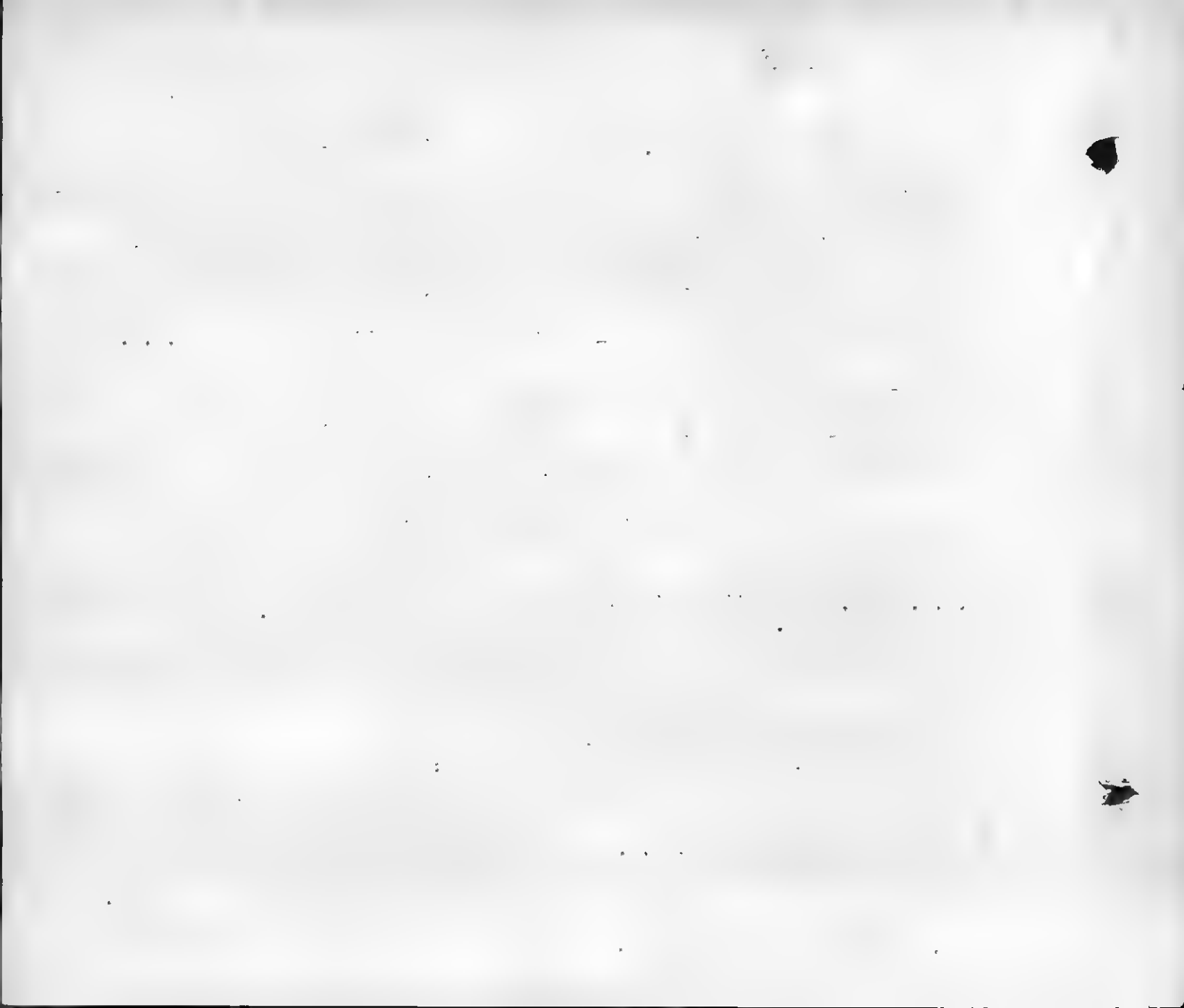
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg - RFD #2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>None</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Minnie Magnolia Cobb Gibbs</b>		4. DATE OF DEATH Month Day Year <b>February 6, 1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 20, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11 BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Unknown - last name Cobb</b>		14. MOTHER'S MAIDEN NAME <b>Martha Walston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b> <b>Bronchopneumonia.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 1958</b> , to <b>February 6, 1959</b> , that I last saw the deceased alive on <b>February 6, 1959</b> , and that death occurred at <b>9:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
DATE SIGNED <b>2/6/59</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>2-8-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Norfolk Va.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 9 '59</b>		24b. REGISTRAR'S SIGNATURE <i>F. W. Kraiss</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

01730

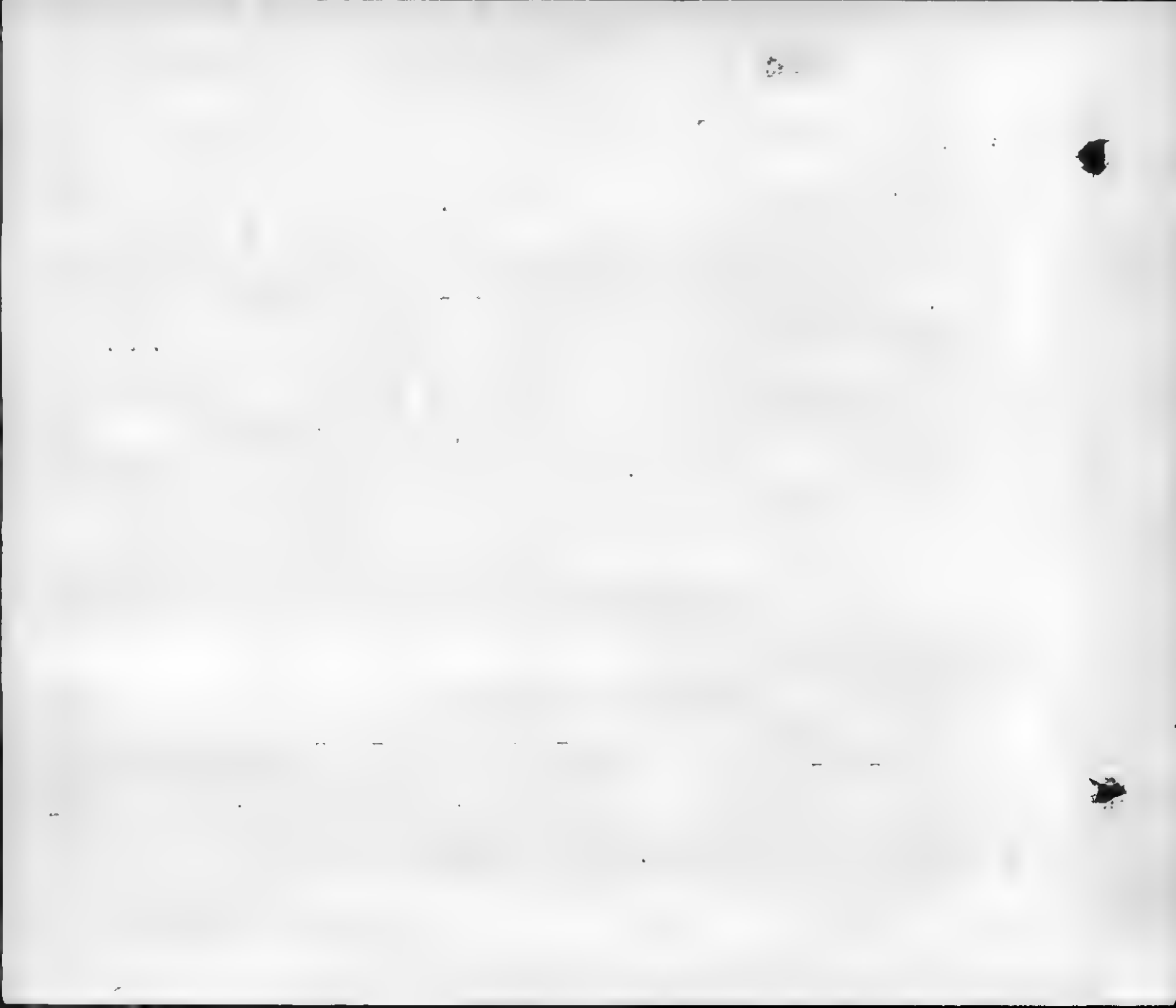
Reg. Dist. No.

1727

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 y 10 m 27 d</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2413 E. Hoffman Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>George</b> Last <b>Goldbeck</b>				4. DATE OF DEATH Month <b>2</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-93</b>		9. AGE (In years last birthday) <b>65</b> yrs	IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>19</b> Min.	IF UNDER 24 HRS Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William J. Goldbeck</b>				14. MOTHER'S MAIDEN NAME <b>Sophie Nissen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>unkn</b>		17. INFORMANT <b>Springf. State Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of prostate</b> <b>177x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involutional psychotic reaction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year plus</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 - 17 - 1956</b> to <b>2 - 13 - 1959</b> , that I last saw the deceased alive on <b>2 - 13 - 1959</b> , and that death occurred at <b>5:20 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) <b>M.D. Springfield State Hospital</b>		DATE SIGNED <b>2-14-59</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>		22d. LOCATION (City, town or county) (State) <b>BALTIMORE Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Pulaski</b>				ADDRESS <b>2818 E. BALTIMORE ST.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 19 1959</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. S. J.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1728

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN lb <i>2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nurs Home</i>		d. STREET ADDRESS <i>038-2</i>	
3. NAME OF DECEASED (Type of print) <i>GEORGE - MILLARD - HALE</i>		4. DATE OF DEATH <i>Feb 6 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 5 - 1889</i>
9. AGE (In years last birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harmer</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John C Hale</i>	
14. MOTHER'S MAIDEN NAME <i>Emma Waigand</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give dates of service) <i>No</i>	
16. SOCIAL SECURITY NO <i>No</i>		17. INFORMANT <i>Millard R Hale</i> Address <i>Upper Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Bronchitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Recurrent Tumor + mixed and secondary</i> DUE TO <i>the malignancy + to the common Venous thrombosis</i> (c) <i>Decubitus Ulcers</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 1950, to <i>Feb 6</i> , 1959, that I last saw the deceased alive on <i>Feb 5</i> , 1959, and that death occurred at <i>24</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W H Foard</i> M.D.		ADDRESS (Street, city or town, state) <i>Manchester, Md</i> DATE SIGNED <i>2/7/59</i>	
PHYSICIAN'S NAME (Type) <i>W H Foard, MD</i>		<i>Manchester, Md</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-4-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wm Carroll</i>	22d. LOCATION (City, town, or county) (State) <i>Balto ES Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E Tipton</i> ADDRESS <i>Hagerstown Md</i>		24a. REC'D BY REGISTRAR <i>FEB 9 '59</i>	24b. REGISTRAR'S SIGNATURE <i>William S. H. Jr</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1729

## CERTIFICATE OF DEATH

Reg. Dist. No.

01732

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton, Maryland</u>				c. LENGTH OF STAY IN 1b <u>560 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				d. STREET ADDRESS <u>2901 Windsor Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Hamm</u> Last <u>Hamm</u>				4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 18, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Danville, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Alexander Miller</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Fannie Hamm - Patient</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Minimal pulmonary tuberculosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Henryton, Maryland</u>		(County) (State)	
21. I certify that I attended the deceased from <u>July 25</u> , 19 <u>57</u> , to <u>Feb. 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 5</u> , 19 <u>59</u> , and that death occurred at <u>7:00 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. M. Maculans M.D.</u>				DATE SIGNED <u>2-5-59</u>			
PHYSICIAN'S NAME (Type) <u>E. M. Maculans, M. D., Supt.</u> <u>Henryton State Hospital</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CATH. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. COUNTY - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RANDOLPH CULLICK - 142 E. PRESTON ST.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. 8 HAWA</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

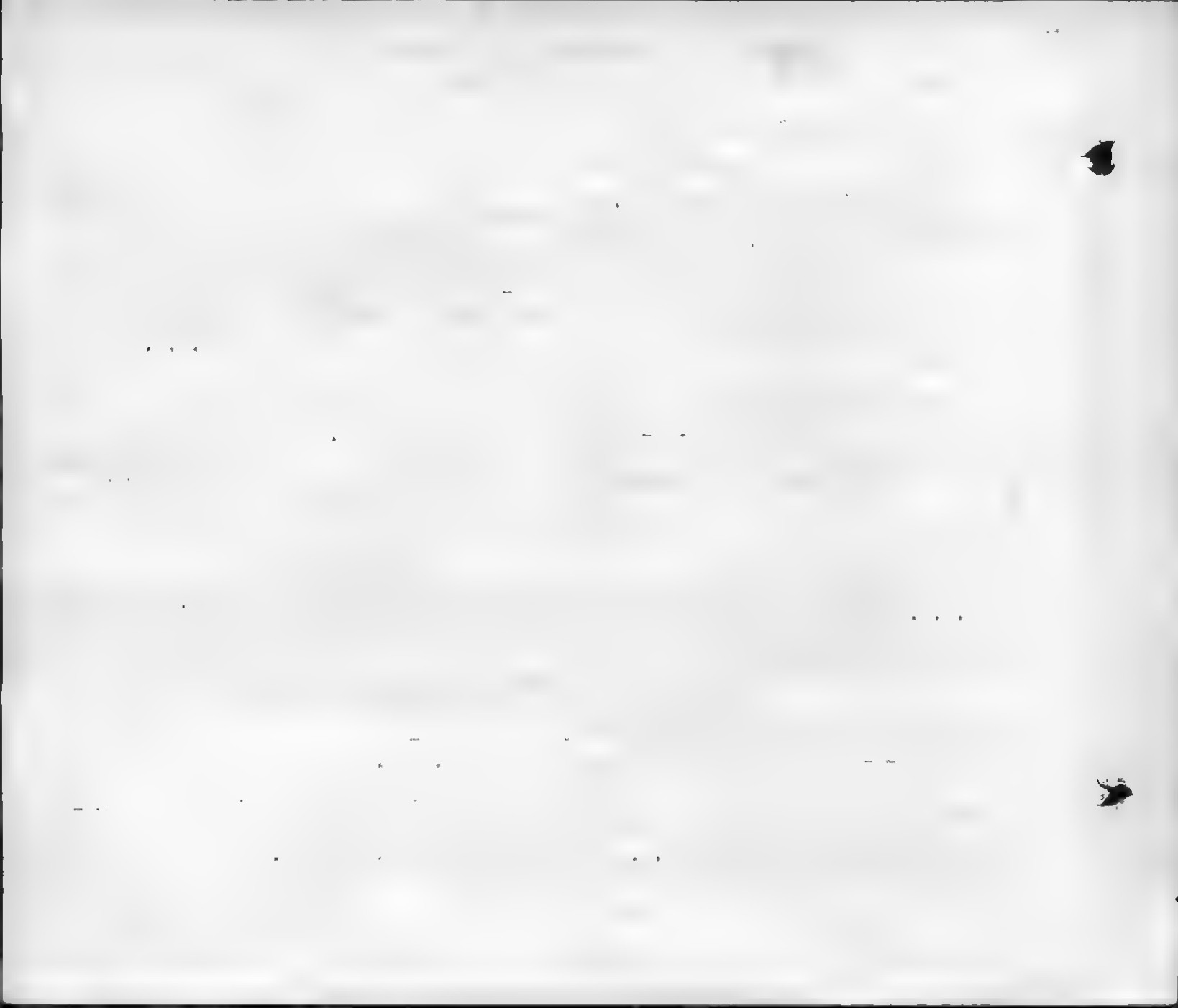
1730

## CERTIFICATE OF DEATH

Reg. Dist. No. 01733

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 mths-27days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>				d. STREET ADDRESS <b>Unknown</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Augustus</b> Last <b>Harmon</b>				4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-21-74</b>	
9. AGE (In years last birthday) <b>85</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>19</b> Min. <b>59</b>		IF UNDER 24 HRS. Months <b>2</b> Days <b>1</b> Hours <b>19</b> Min. <b>59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser in factory</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Augustus Harmon</b>				14. MOTHER'S MAIDEN NAME <b>Marthe Rapp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO <b>212-01-8756</b>			
17. INFORMANT <b>Hospital records.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							
DUE TO <b>Generalized Arteriosclerosis</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO <b>Generalized Arteriosclerosis</b>							
DUE TO <b>Generalized Arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis with psychotic reaction</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12-5-58</b> to <b>2-1-59</b> , that I last saw the deceased alive on <b>2-1-59</b> , and that death occurred at <b>5.00 A.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-1-59</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b>							
PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b> <b>Sykesville, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Taylorville</b>		22d. LOCATION (City, town, or county) (State) <b>Taylorville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. D. Hartzler &amp; Son</b>				24a. REC'D BY REGISTRAR <b>NEW WINDSOR MD</b>			
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hines</b>				DATE <b>FEB 4 '59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01734

1731

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lineboro Rural</u>				c. LENGTH OF STAY IN 1b <u>33 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rollen Road</u>				e. STREET ADDRESS <u>Rollen Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Frederick Marshall</u>				4. DATE OF DEATH Month Day Year <u>February 18 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick R Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Stiffler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>E. Mabel Marshall</u> Address <u>Lineboro Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <u>Chronic Myocarditis</u> (c). <u>(?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JAN 15 1959</u> , to <u>February 18 1959</u> , that I last saw the deceased alive on <u>February 16 1959</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>2/18/59</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				LOCATION (City, town, or county) (State) <u>HAMPSTEAD Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Febr. 20 1959</u>		<u>Pine Grove Cemetery</u>		<u>Park Ton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Northrup</u> ADDRESS <u>New Freedom Pa.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>FEB 20 1959</u>							

MEDICAL CERTIFICATION

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01735

1732

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto 7</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>	
c. LENGTH OF STAY IN lb <u>1 month</u>		d. STREET ADDRESS <u>8401 Eastwood Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Witzel Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>M.</u> Middle <u>Elbert</u> Last <u>JEAN</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22, 1877</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired office work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockdale</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>W. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Katharine Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>Mr Gordon S. Power</u>	
17. INFORMANT <u>34 W. Chesapeake Ave 4</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease,</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis, bronchitis,</u> DUE TO (c) <u>Arteriosclerosis generalized</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 Feb 59</u> <u>25 Feb 59</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>2 Feb</u> , 19 <u>59</u> , to <u>25 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>25 Feb</u> , 19 <u>59</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Severnville, Md</u>	
DATE SIGNED		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>2/27/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wit. Calver cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u> ADDRESS <u>8728 Liberty Road</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE	



01736

**FOR STATE  
HEALTH DEPT.**

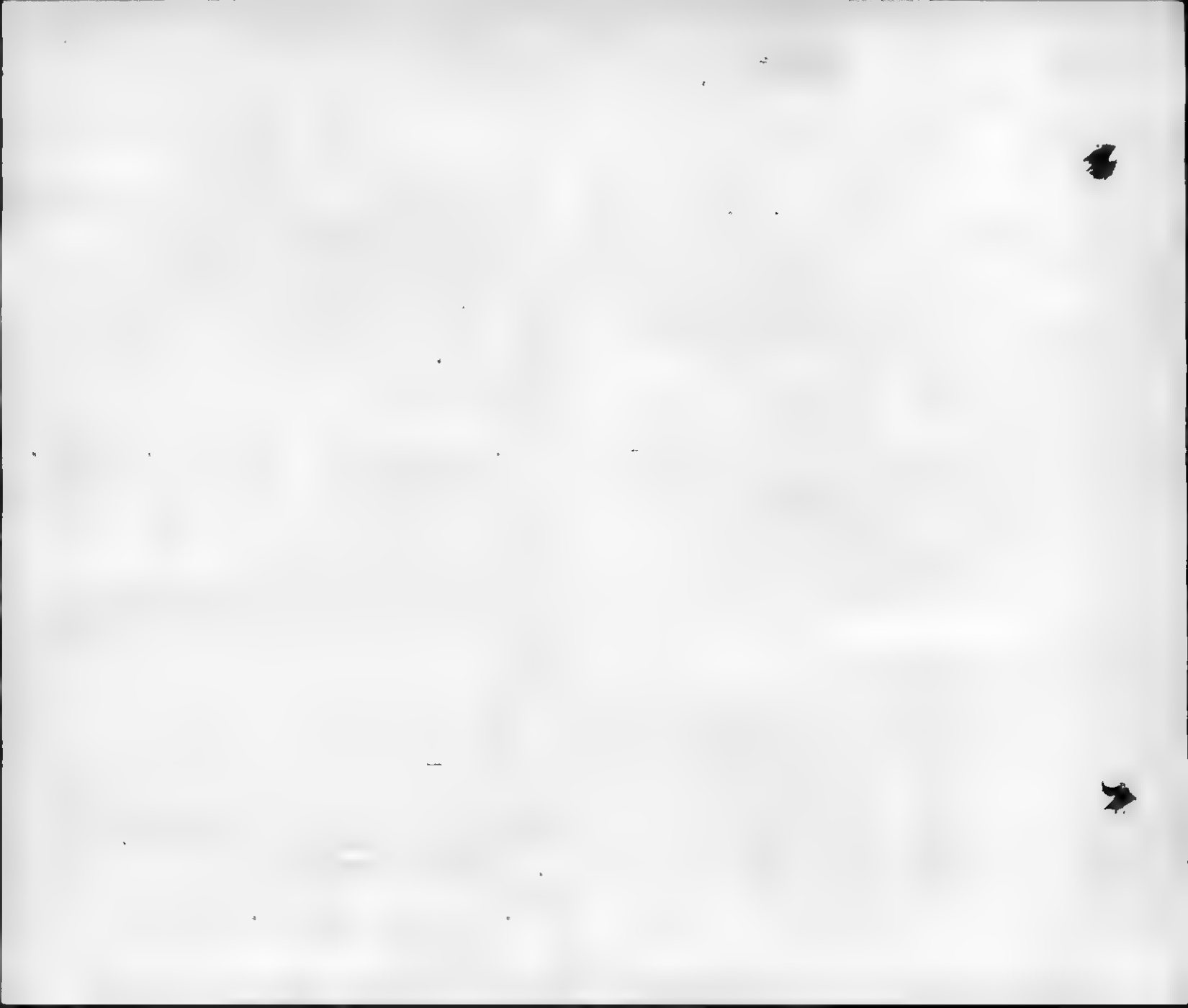
1733

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 F11mG2 38 2-9-59 et

Reg. Dist No

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Taneytown, Md. (Neal's Farm)</b>		d. STREET ADDRESS <b>Taneytown, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Henry Kaiser</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1866</b>		9. AGE (In years last birthday) <b>72</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pa.</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Henry Kaiser</b>		14. MOTHER'S MAIDEN NAME <b>Rose Abell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>163-24-9777A</b>		17. INFORMANT <b>Mrs. Mertie Kaiser - Taneytown, R. D. 1, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420.1</b> DUE TO <b>coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William V. Lovitt Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>February 4, 1959</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL CREMATION REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/6/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cem.</b>	
22d. LOCATION (City, town, or county)		22e. (State)		<b>Hanover, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckener &amp; Sons - Baltimore, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. H. H.</b>					





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

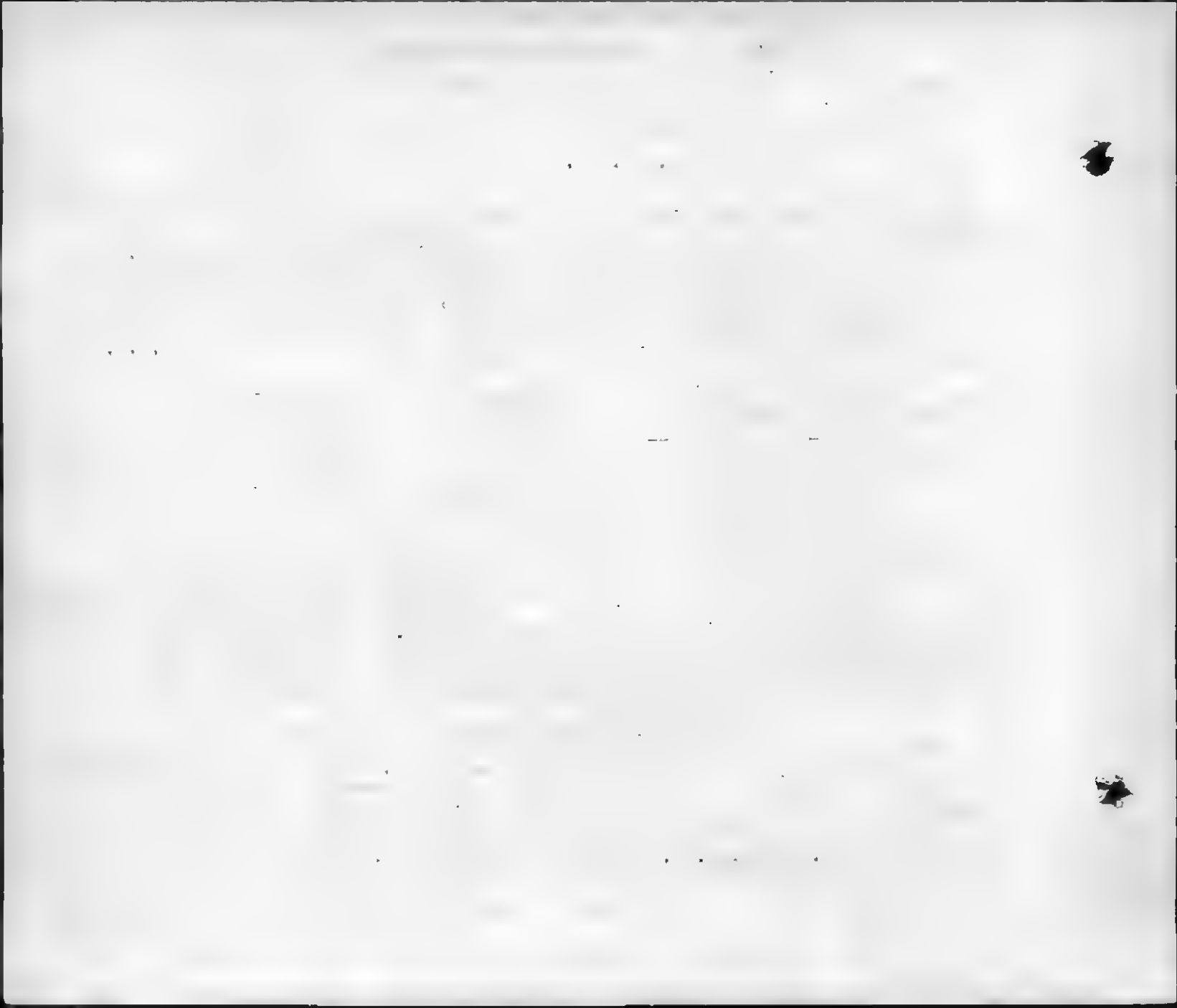
1734

## CERTIFICATE OF DEATH

01737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1y. 8m. 7d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1627 Lancaster Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Kowalski</b> Last <b>Kowalski</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1884</b>	9. AGE (In years last birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Zborowski</b>				14. MOTHER'S MAIDEN NAME <b>Katherine --</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Springfield State Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b> <b>4 2 2 1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 24, 1957</b> to <b>February 26, 1959</b> , that I last saw the deceased alive on <b>February 26, 1959</b> , and that death occurred at <b>6:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Pita S. Glahn</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/27/59</b>			
PHYSICIAN'S NAME (Type) <b>Pita S. Glahn, M. D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>7300 Germantown Road Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George G Weber</b>				ADDRESS <b>705 S Ann St</b>		24a. REC'D BY REGISTRAR <b>MAR 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. S. ...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

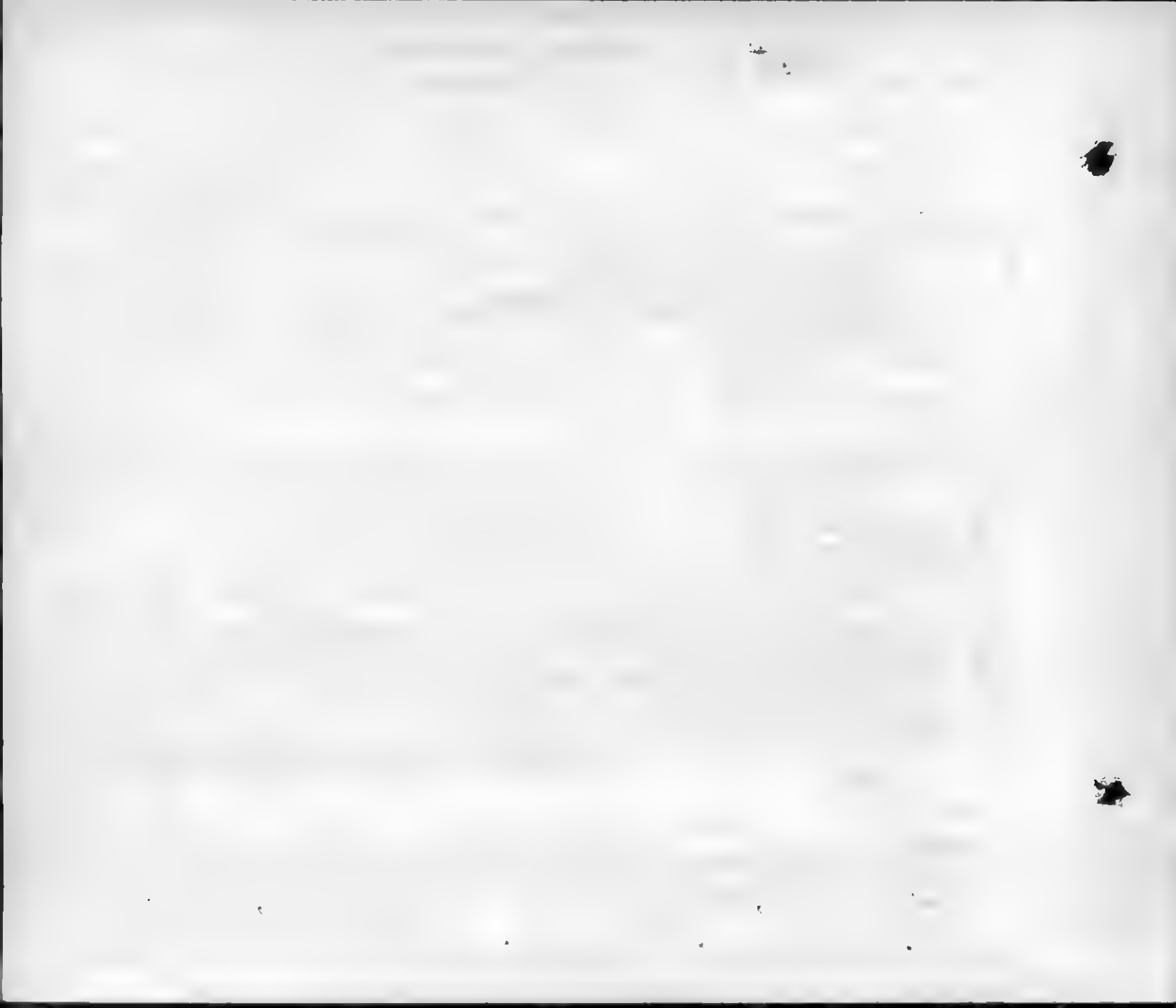
1735

## CERTIFICATE OF DEATH

Reg. Dist. No.

01738

1 PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gettysburg</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
c. LENGTH OF STAY IN 1b <i>11-20-27</i>				d. STREET ADDRESS <i>319 N. E. Wood</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>Thomas Lahey</i>				4. DATE OF DEATH Month <i>2</i> Day <i>15</i> Year <i>1959</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 1876</i>	
9. AGE (In years last birthday) <i>83</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Thomas Lahey</i>				14. MOTHER'S MAIDEN NAME <i>Annie Redden</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolus</i> <i>463x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Thrombophlebitis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Psychosis with cerebral arteriosclerosis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <i>3-7</i> , 19 <i>55</i> , to <i>2-15</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-15</i> , 19 <i>59</i> , and that death occurred at <i>5:00 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Agustín del Campo</i> M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>Feb 18, 1959</i> 22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cent</i> 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> 23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Baltimore St.</i> 24a. REC'D BY REGISTRAR <i>FEB 17 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Wm. J. G. G.</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01739

1736

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keysmar</u>		c. LENGTH OF STAY IN 1b <u>37 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. STREET ADDRESS <u>X Keysmar</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE ALBERTA LEAKINS</u>		4. DATE OF DEATH Month Day Year <u>Feb. 14 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William R. Clabaugh</u>		14. MOTHER'S MAIDEN NAME <u>Annie Hartsch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr John J. Leakins, Keysmar Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr or</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 13</u> , 19 <u>59</u> , to <u>Feb 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>59</u> , and that death occurred at <u>2:00</u> PM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Keysmar, Md</u> DATE SIGNED <u>Feb 16</u>			
ACTUAL SIGNATURE <u>J. H. Messlet</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. H. MESSLET</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keysmar Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. J. Barton</u> ADDRESS <u>Wheatonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 18 '59</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1737

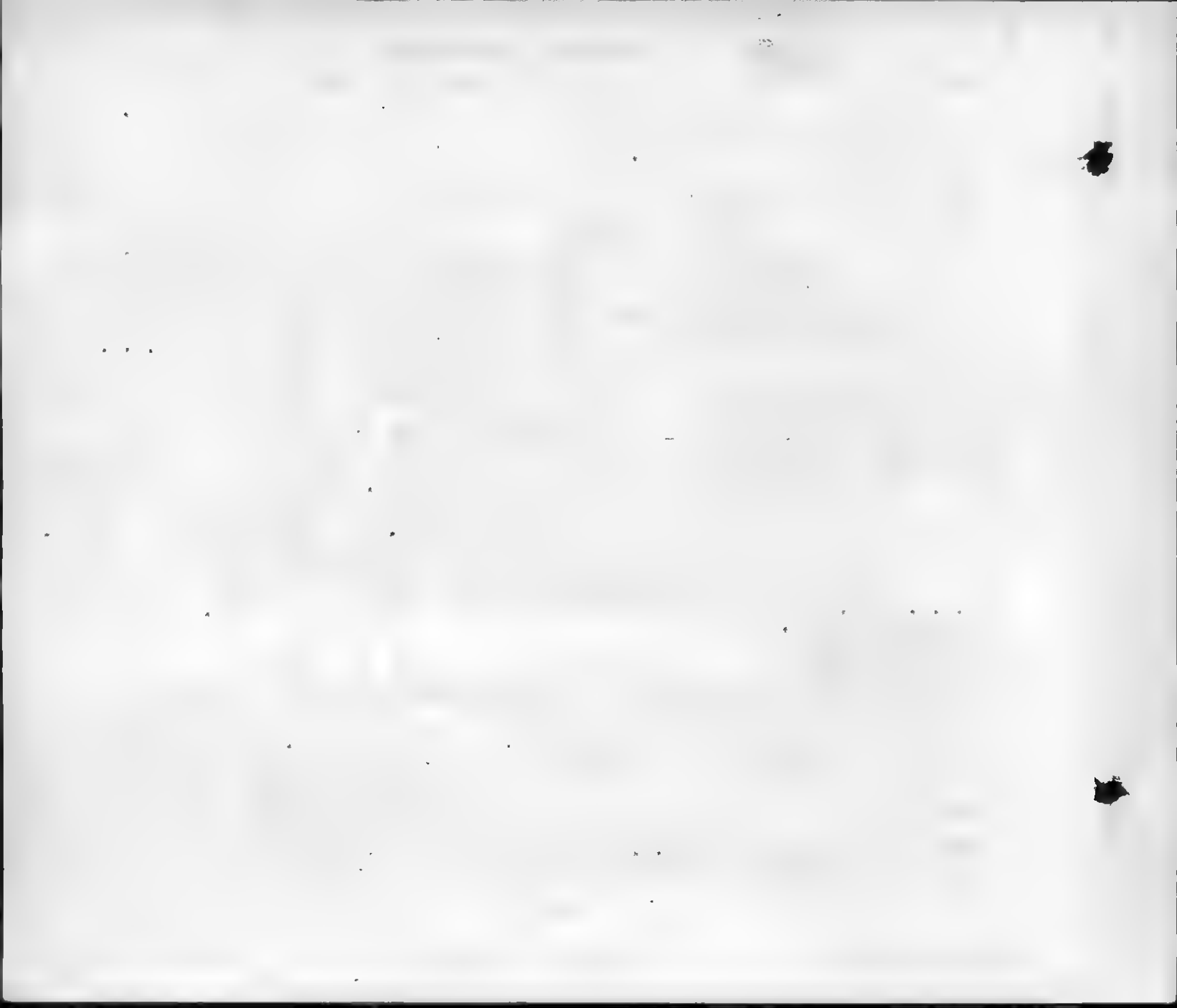
## CERTIFICATE OF DEATH

01740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2mos. 27days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Randolph</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b> <b>Years.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>November 18, 1958</b> , to <b>February 15, 1959</b> , that I last saw the deceased alive on <b>February 14, 1959</b> , and that death occurred at <b>2:15 A.M.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>		DATE SIGNED <b>2/15/59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b> ADDRESS <b>8, 1st St.</b>		24a. REC'D BY REGISTRAR DATE <b>2/15/59</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

01741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2yrs.19days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			
				d. STREET ADDRESS <b>Main Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Last <b>Clementine Makinson</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 12, 1873</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Makinson</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Deane Isaacs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis, severe.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years.</b> <b>years.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 17, 1957</b> to <b>February 6, 1959</b> , that I last saw the deceased alive on <b>February 5, 1959</b> , and that death occurred at <b>8:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/6/59</b>							
ACTUAL SIGNATURE <i>Agustin del Campo</i>		M.D. <b>Springfield State Hospital</b>					
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR <b>FEB 9 1959</b>		24b. REGISTRAR'S SIGNATURE <i>(Signature)</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01742

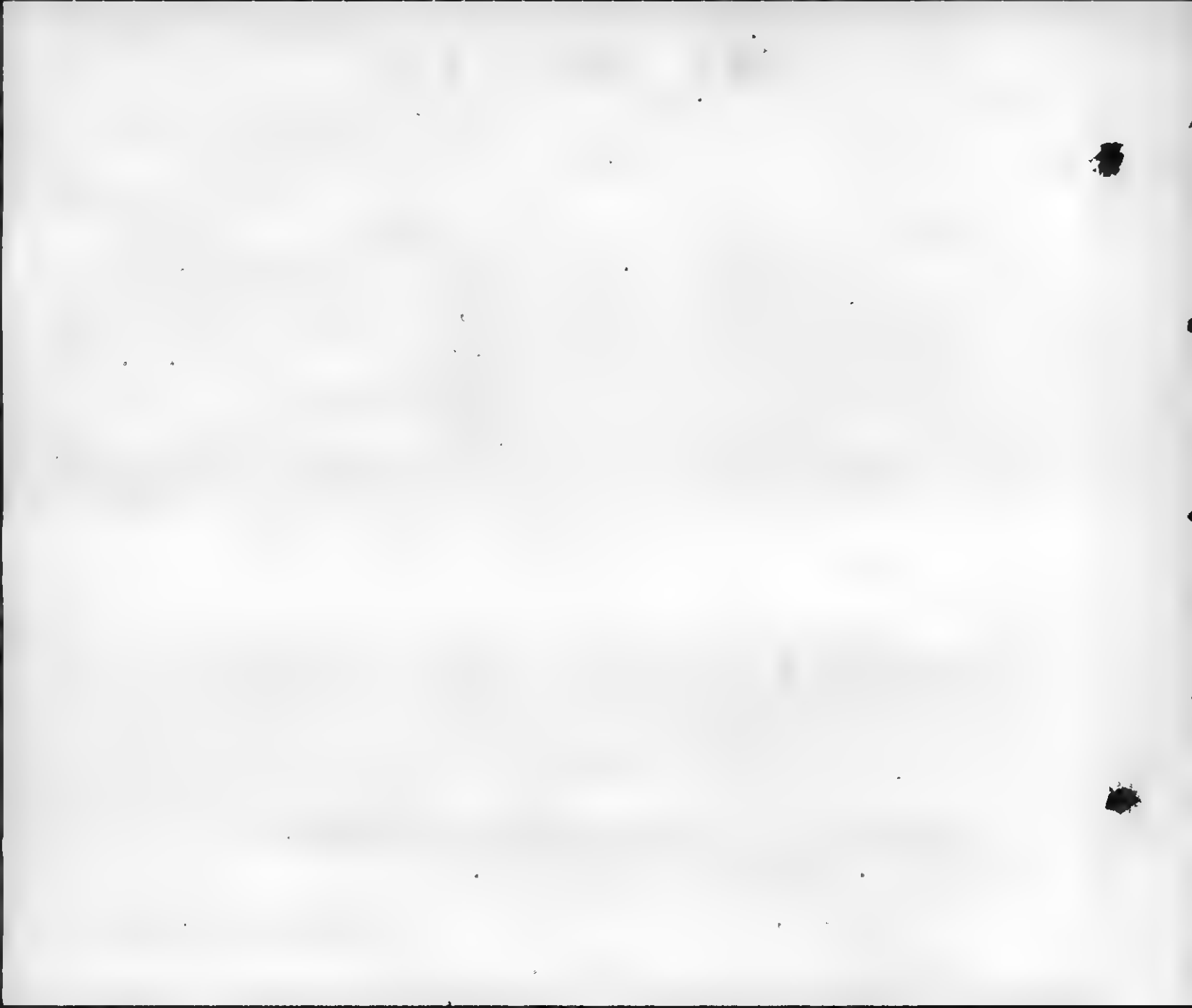
1739

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frizelburg</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Frizelburg</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles S. Marker</b>				4. DATE OF DEATH Month Day Year <b>February 12, 1959 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1868</b>	9. AGE (In years last birthday) <b>90 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Marker</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Warehime</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Walter Marker, Westminster, Maryland R.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>arteriosclerotic cardio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>vessel disease &amp;</b> DUE TO <b>Hypertension</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b> <b>5-79-20</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1958, to <b>Feb 12</b> , 1959, that I last saw the deceased alive on <b>Feb 12</b> , 1959, and that death occurred at <b>11:15 P.</b> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>W. Glenn Speicher, Westminster, Md.</b> <b>2/13/59</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>W. Glenn Speicher, Westminster, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 16, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baust Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tyrone, Carroll, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

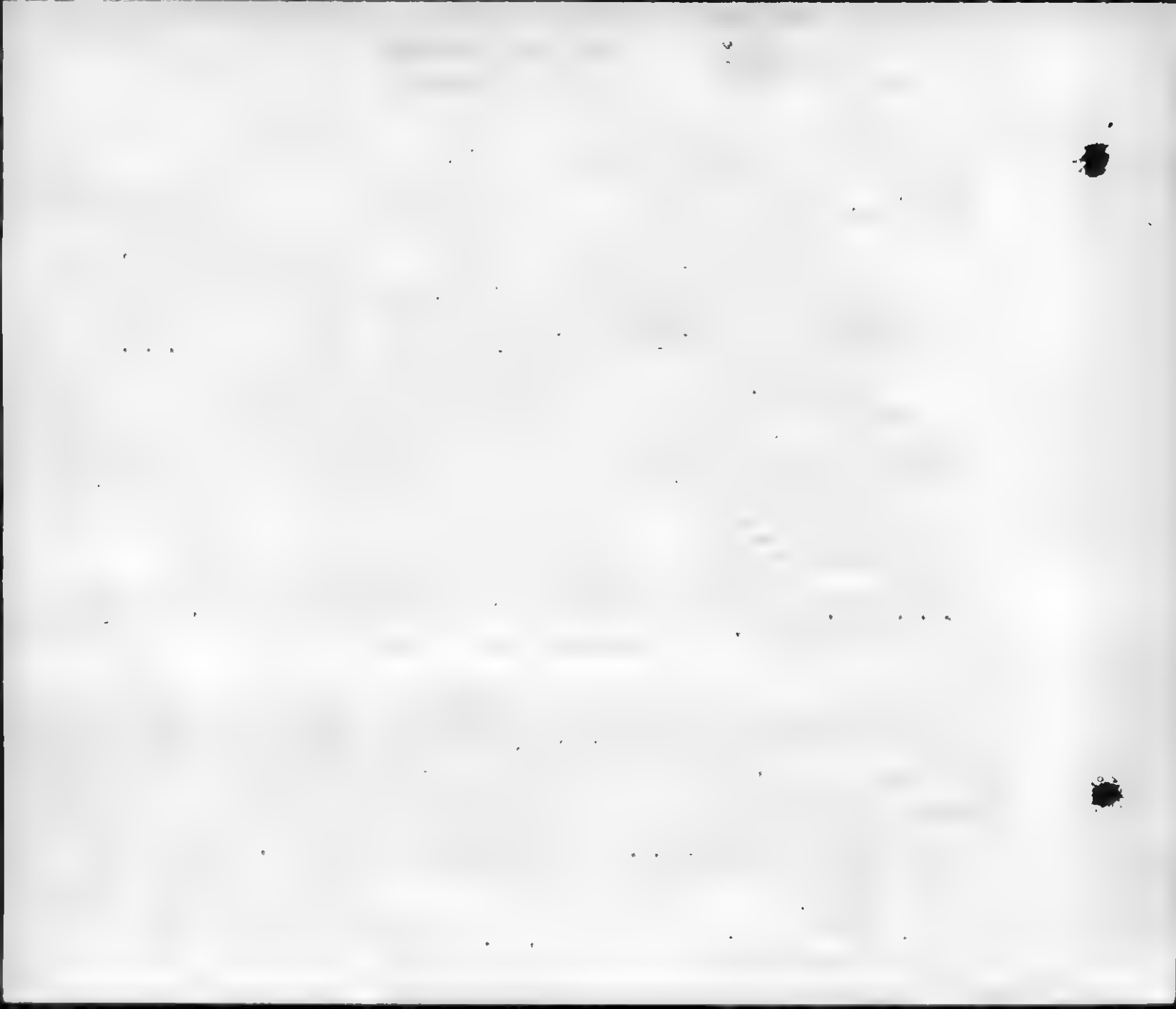
01743

1740

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield State Hospital</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sykesville, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>George</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1887</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Analyst &amp; SUPERVISOR RESTAURANT EQUIP.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES W. MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE (unknown)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>yes</b>	
16. SOCIAL SECURITY NO <b>yes</b>		17. INFORMANT <b>Springfield Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month <b>February</b> Day <b>9</b> Year <b>1959</b> Hour <b>a. m.</b> p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Springfield Hospital</b>		20g. (County) <b>Montgomery</b>	
20h. (State) <b>Maryland</b>		21. I certify that I attended the deceased from <b>February 9, 1959</b> , to <b>February 24, 1959</b> , that I last saw the deceased alive on <b>February 24, 1959</b> , and that death occurred at <b>7:17 PM</b> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>		23. DATE SIGNED <b>2/25/59</b>	
24. ACTUAL SIGNATURE <b>Agustin del Campo</b>		25. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		26. ADDRESS <b>Sykesville, Maryland.</b>		27. SIGNATURE <b>Agustin del Campo</b>	
28. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		29. DATE THEREOF <b>2/28/59</b>		30. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>		31. LOCATION (City, town, or county) <b>ROCKVILLE, MARYLAND</b>	
32. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		33. ADDRESS <b>SILVER SPRING, MD.</b>		34. REC'D BY REGISTRAR <b>FEB 26 '59</b>		35. REGISTRAR'S SIGNATURE <b>Colin S. H. H.</b>	



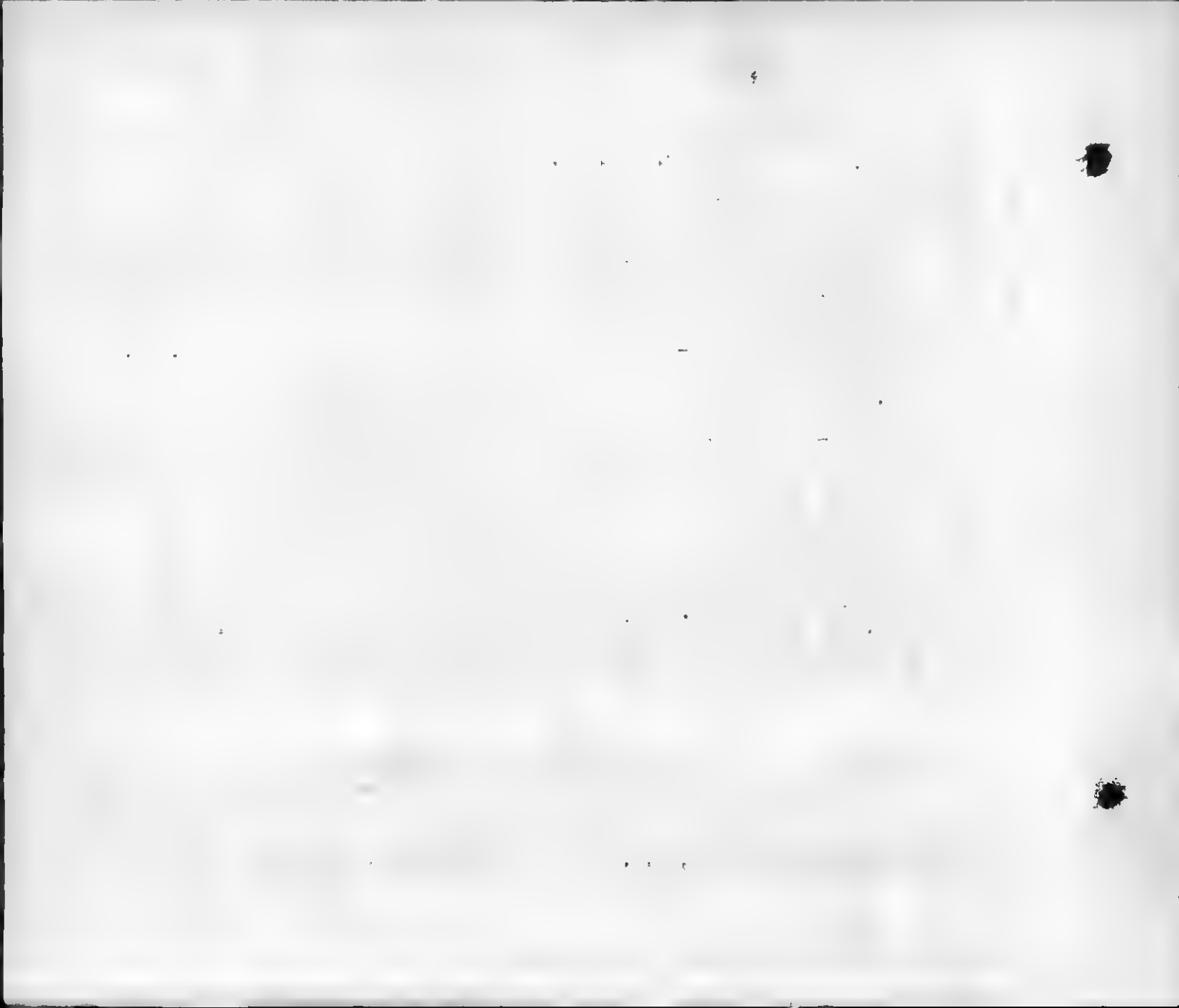
1741

CERTIFICATE OF DEATH

01744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN TB <u>2yr.10mo.13d.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ijamsville</u>			
				d. STREET ADDRESS <u>10 X</u>			
3. NAME OF DECEASED (Type or print) First <u>Emanuel</u> Middle <u>Ruth</u> Last <u>Nagle</u>				4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/16/74</u>	
				9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas F. Nagle</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hutcherson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>-</u>			
				17. INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic rheumatic heart disease</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the prostate.</u> <u>CBS ASSOC. with cerebral arteriosclerosis with psychotic reaction.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/20/</u> 19 <u>56</u> , to <u>2/3/</u> 19 <u>59</u> , that I last saw the deceased alive on <u>2/3/</u> 19 <u>59</u> , and that death occurred at <u>1:30p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2/3/59</u>							
ACTUAL SIGNATURE <u>Agustin del Campo</u>							
PHYSICIAN'S NAME (Type) <u>Agustin Del Campo, M.D.</u> <u>Sykesville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W. W. McMillan Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Cooptown Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Jones</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 6 '59</u>			
ADDRESS <u>Bel Air Md</u>				24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1742

## CERTIFICATE OF DEATH

Reg. Dist. No.

01742

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster RD #6</u>				d. STREET ADDRESS <u>Westminster RD #6</u>			
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>GERTRUDE</u> Last <u>NELSON</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Price</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Case</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Martha M. Nelson, Westminster Md. Rd. #6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 442x DUE TO <u>Arteriosclerosis &amp; cardiac</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Vascular Renal disease</u> (b) <u>Arteriosclerosis &amp; cardiac</u> (c) <u>Vascular Renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> to <u>Feb 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>59</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Angela Speicher</u>				ADDRESS (Street, city or town, state) <u>Westminster Md.</u>			
PHYSICIAN'S NAME (Type) <u>Feb 2/1959</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>FEB. 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>				24. REC'D BY REGISTRAR <u>Feb 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Myers, Jr.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



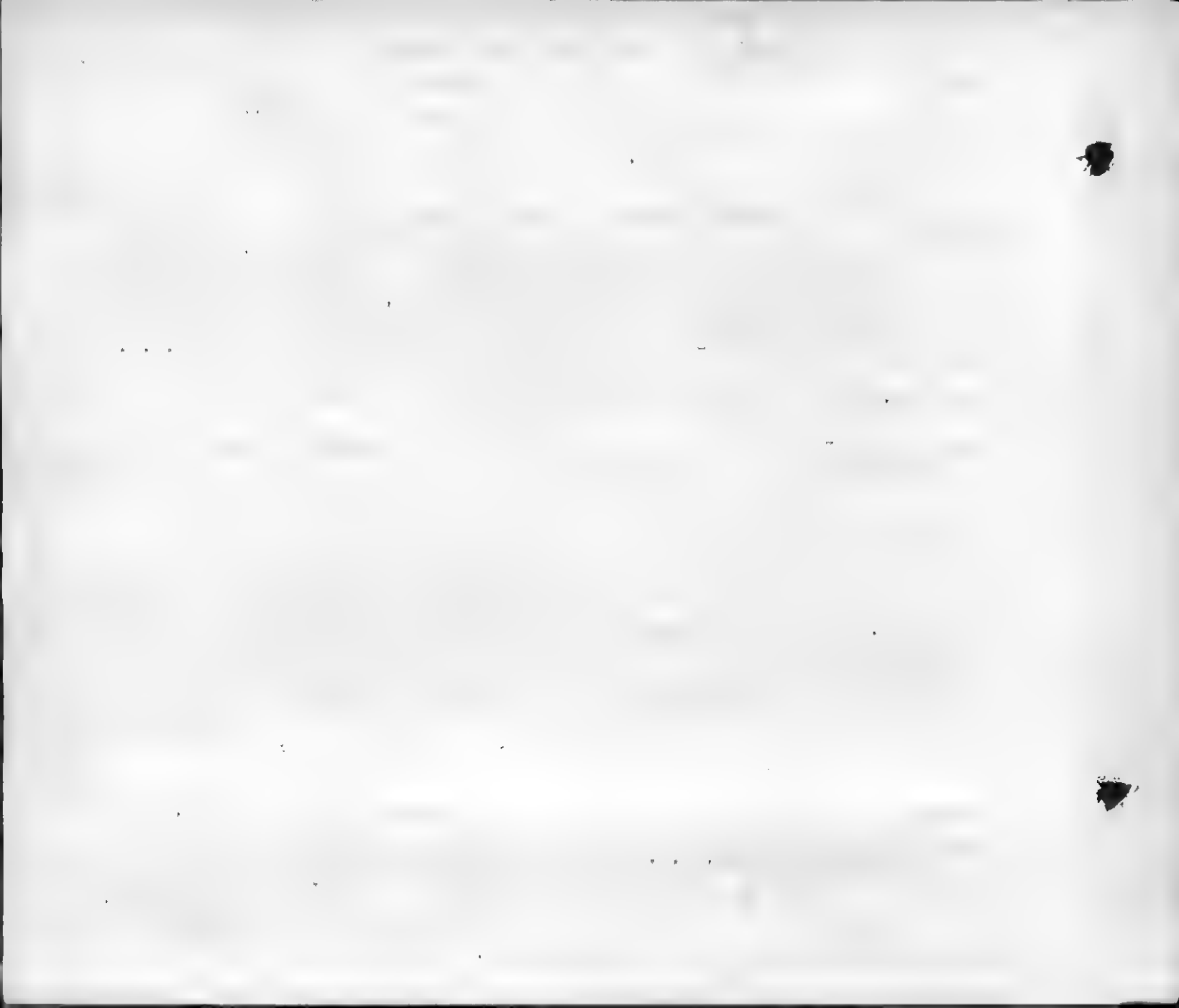
1743

CERTIFICATE OF DEATH

01746

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 mo. 12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Virginia</b> Last <b>Nicholson</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 30, 1874</b>	9. AGE (In years last birthday) <b>84</b> yrs	IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Eby</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane File</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>471x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS ASSOC. WITH CEREBRAL ARTERIOSCLEROSIS, WITH PSYCHOTIC REACTION.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 13, 19 58</b> , to <b>February 24, 19 59</b> , that I last saw the deceased alive on <b>February 24, 19 59</b> , and that death occurred at <b>8:05p M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital, 2/25/59</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC BALTIMORE MD.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 27 59</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Thane</b>	



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1744

01747

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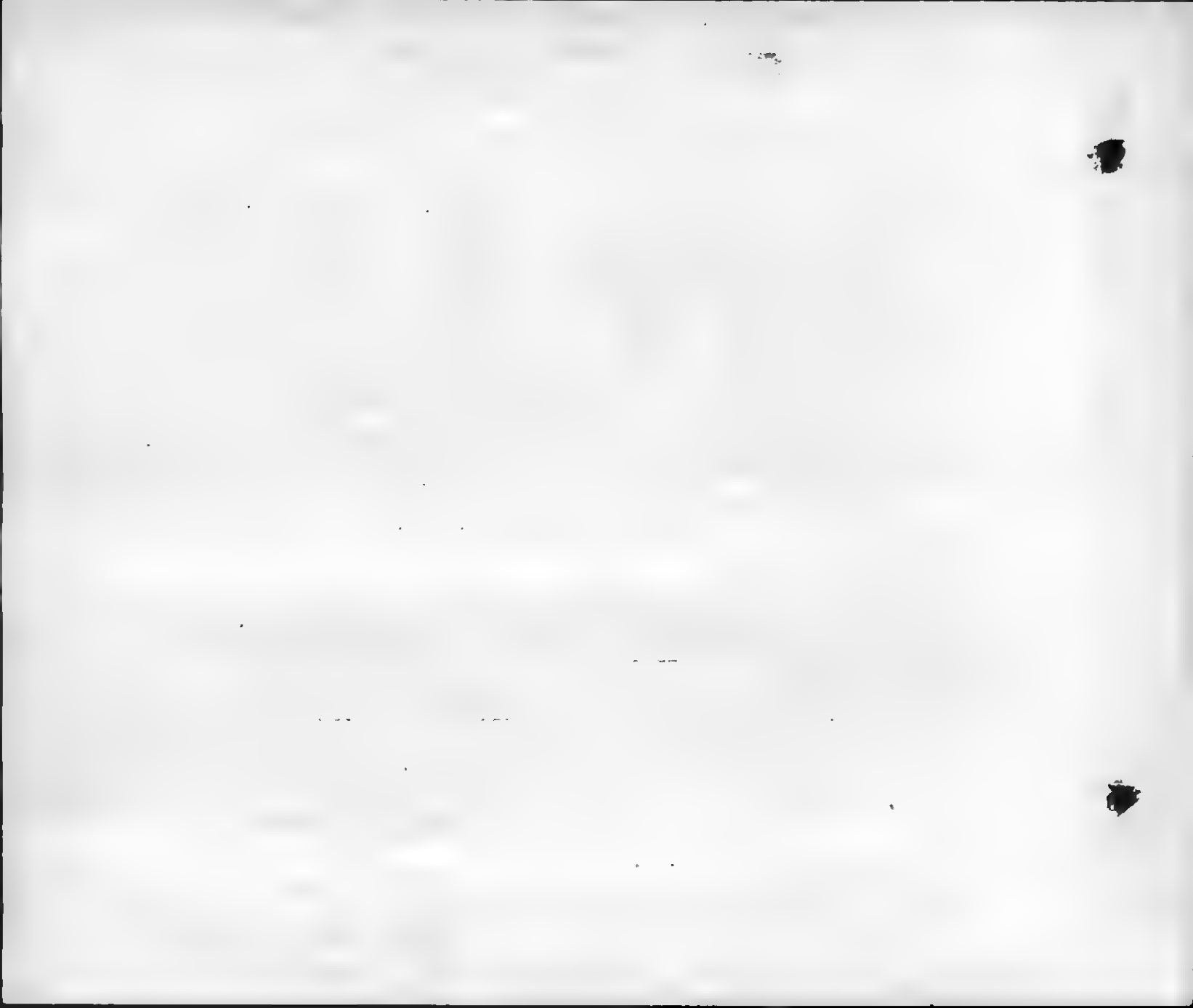
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>810 S. Ellwood Avenue</b>			
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MAVIS</b> Middle <b>MAY</b> Last <b>PERRY</b>		4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/29/95</b>		9. AGE (In years last birthday) <b>63</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Forrest</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ridgell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Record, Springfield State Hospital, Sykesville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>----</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>----</b> 19 p. m. <b>----</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>----</b>		20f. (City or town) (County) (State) <b>----</b> <b>----</b> <b>----</b>	
21. I certify that I attended the deceased from <b>2/2</b> , 19 <b>59</b> , to <b>2/19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/19</b> , 19 <b>59</b> , and that death occurred at <b>1:15 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>2/19/59</b>							
ACTUAL SIGNATURE <b>Heinz Klaatsch M.D.</b>		PHYSICIAN'S NAME (Type) <b>Heinz Klaatsch, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/23/59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Jones</b>		ADDRESS <b>1305 Fort Ave.</b>		24a. RECEIVED BY REGISTRAR <b>2/19/59</b>		24b. REGISTRAR'S SIGNATURE <b>W. C. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

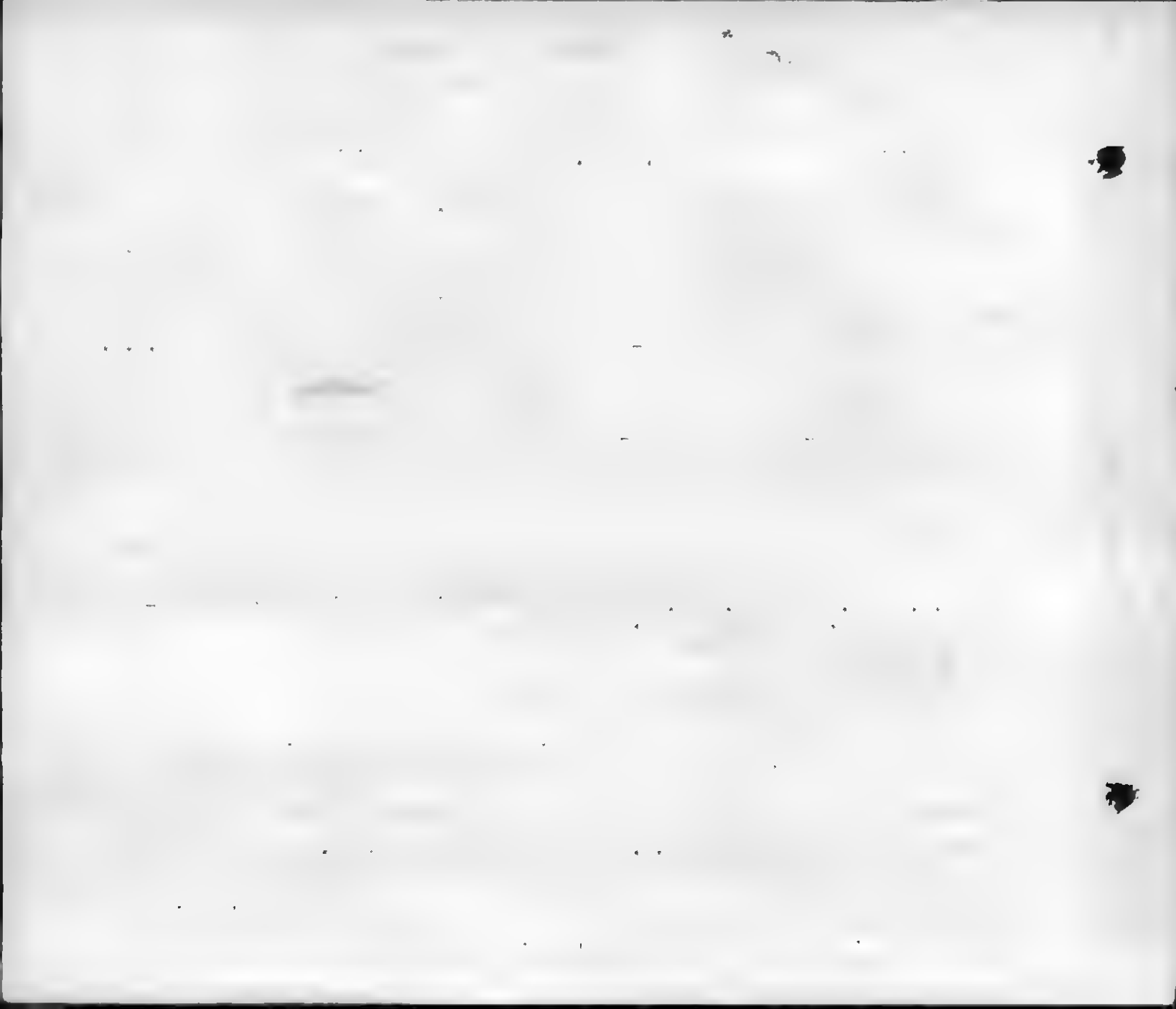
Reg. Dist. No.

01748

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>3yrs. 10mos. 12days</b>		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>17 E. Patrick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Gertrude</b> Last <b>Goolsby Ponton</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 59</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1878</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M.n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>John Goolsby</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Lowe</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO <b>None -</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4200.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis without qualifying phrase. Pyelonephritis.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 31, 1955</b> to <b>February 13, 1959</b> , that I last saw the deceased alive on <b>February 12, 1959</b> , and that death occurred at <b>3:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>2/13/59</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles L. George</b> <b>Cumberland, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>FEB 16 1959</b>	24b. REGISTRAR'S SIGNATURE <b>C. L. George</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01749

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1699

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
c. LENGTH OF STAY IN 1b <u>1 hour</u>		d. STREET ADDRESS <u>118 Thandover Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) <u>MARGARET E. RUTH</u>		4. DATE OF DEATH <u>Feb 21 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-1916</u>
9. AGE (in years last birthday) <u>42</u> yrs		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. Meyer Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Betha H. Besten</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. Paul E. Ruth</u>		Address <u>118 Thandover Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (a), stating the underlying cause last. DUE TO (c) <u>420.1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MIN</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-25-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Protestant</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Houghton</u>		24a. REC'D BY REGISTRAR <u>Wm. H. Houghton</u>	
ADDRESS <u>118 Thandover Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. H. Houghton</u>	
DATE <u>MAR 2 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

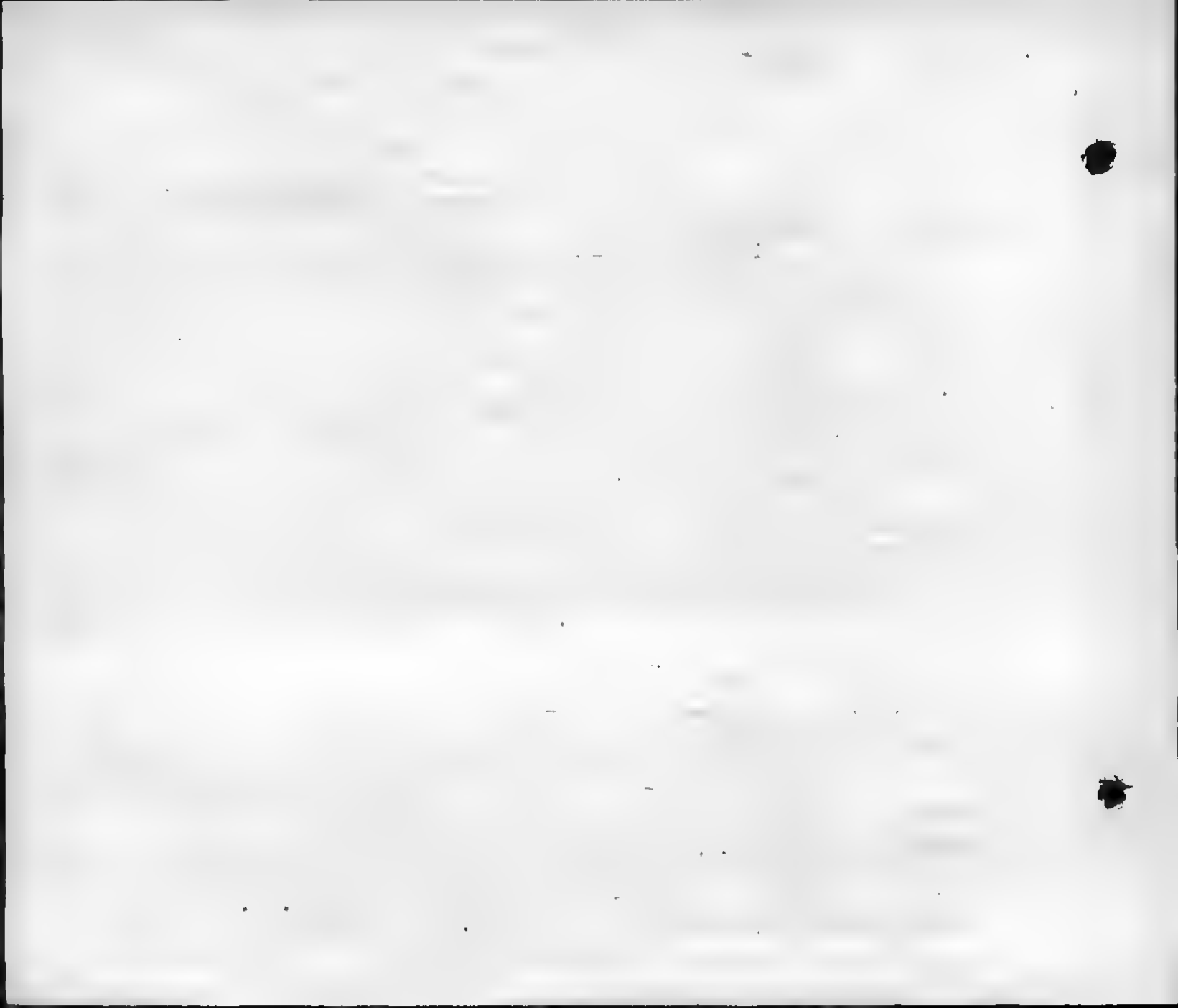
VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
item 2 Filed 10-3-59 at  
1746  
CERTIFICATE OF DEATH

Reg. Dist. No.

01750

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Carroll</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN 1b <b>12yrs. 14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Feilding</b> Middle		4. DATE OF DEATH Month <b>2</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-13-1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Brazil</b>		12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
13. FATHER'S NAME <b>Dr. Stafford Rambo</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Bass</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>unknown</b> (If yes, give war or dates of service) <b>---</b>		17. INFORMANT Address <b>Springfield State Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute peritonitis</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute membranous colitis</b> DUE TO (c) <b>Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Days</b> <b>Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia Praecox, catatonic type.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Hour <b>a. m</b> <b>19</b> p. m <b>---</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) (County) (State) <b>---</b>
21. I certify that I attended the deceased from <b>August 19 1955 2-27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-27</b> , 19 <b>59</b> , and that death occurred at <b>5:06</b> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>---</b>			
ACTUAL SIGNATURE <b>Walter Knopp</b> M.D.		PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b> <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HARRY H. WATKINS</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>



1747

## CERTIFICATE OF DEATH

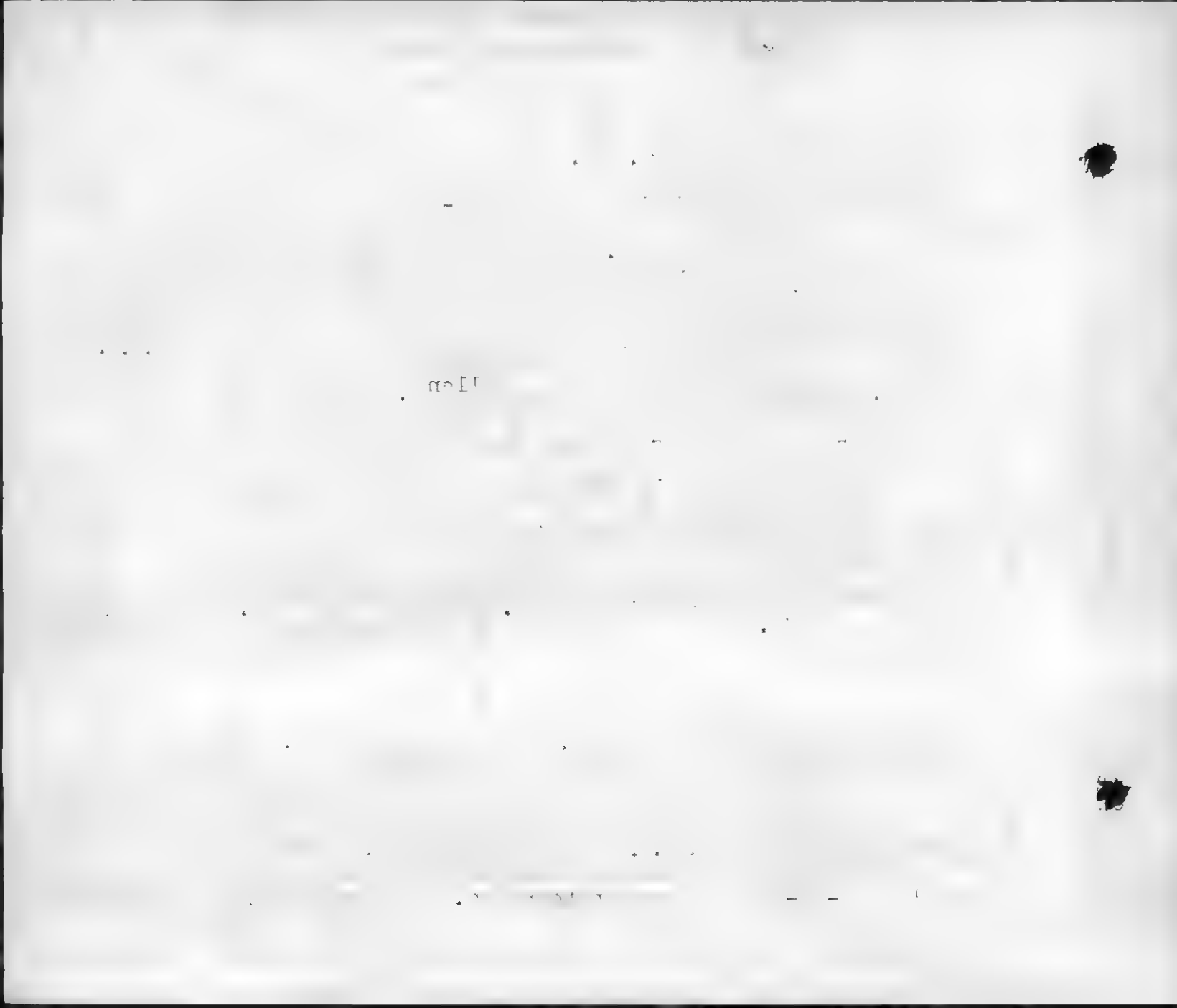
Reg. Dist. No.

01751

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>19yrs. 2mos. 9days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>-</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>E.</b> Last <b>Ramsburg</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 28, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George S. Ramsburg</b>		14. MOTHER'S MAIDEN NAME <b>Ellen L. Holland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral arteriosclerosis. Gangrene, right foot. Bronchopneumonia.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>February 15, 1959</b> that I last saw the deceased alive on <b>February 15, 1959</b> and that death occurred at <b>9:30P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>2/15/59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	
22a. BLR AL. CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Creagerstown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Creagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b> ADDRESS <b>Thurmont Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 19 59</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1748

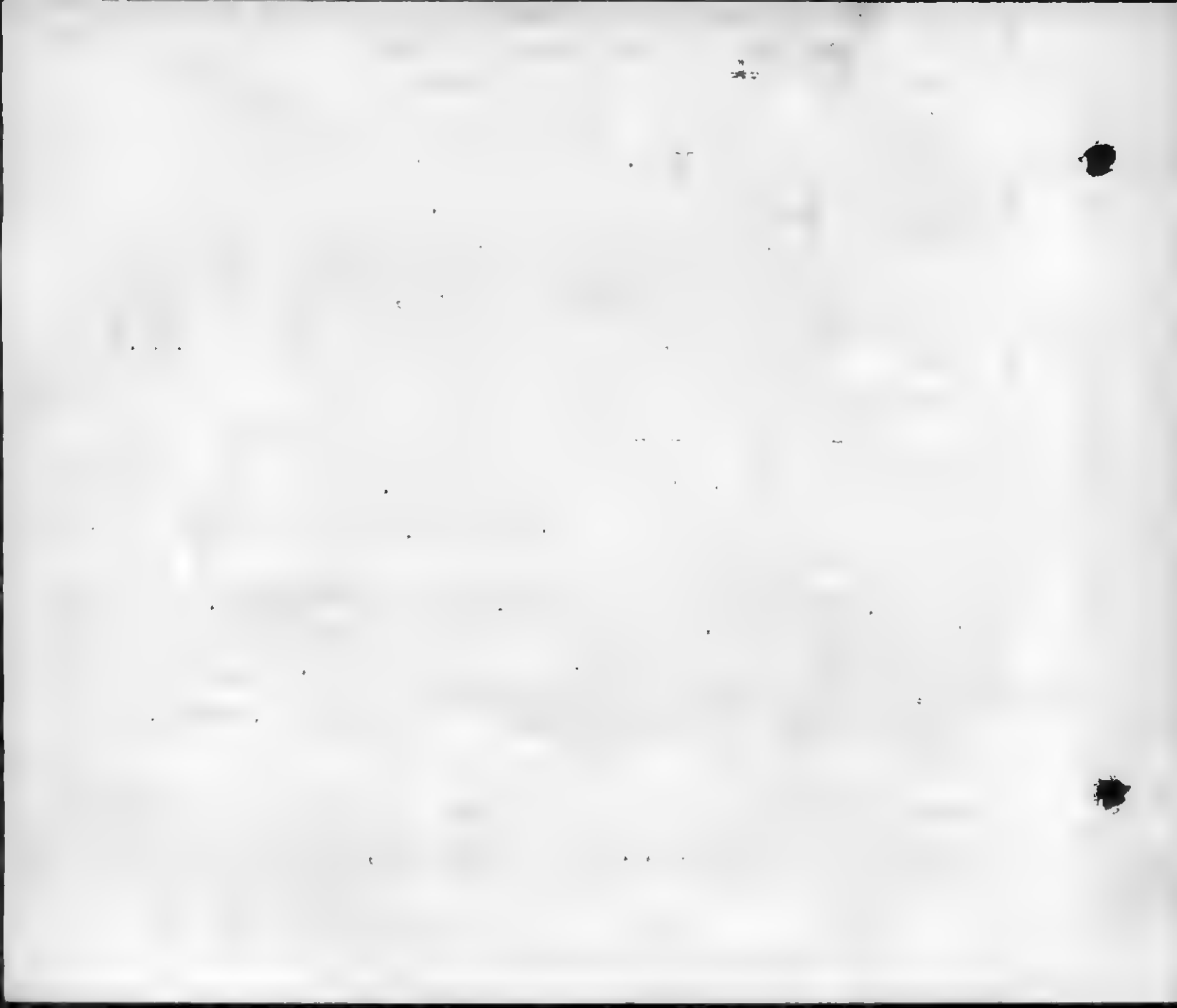
## CERTIFICATE OF DEATH

Reg. Dist. No.

01752

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>19 mo. 22 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1734 E. Lafayette</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bessie Adelle Reid</b>				4. DATE OF DEATH Month Day Year <b>February 20, 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 15, 1871</b>	
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Reid</b>				14. MOTHER'S MAIDEN NAME <b>Carry Clemm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>213-18-7244</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) <b>years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction.</b> <b>Fracture of right elbow.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>Patient fell from chair in dining room.</b>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour <b>6:30 p m</b> <b>1/22/59</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Sykesville, Carroll, Maryland</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>3/28/58</b> , 19___, to <b>2/20/59</b> , 19___, that I last saw the deceased alive on <b>2/20/59</b> , 19___, and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/20/59</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/23/59</b>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>	
22d. LOCATION (City, town, or county) <b>Baltimore</b>				22e. (State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lemard J. Luck</b>				ADDRESS <b>5305 Harford</b>		24a. REC'D BY REGISTRAR DATE <b>EB 24 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Curran S. Evans</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1749

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b (home)		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> d. STREET ADDRESS <b>5 Underwood &amp; Day Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAYMOND L. RIDGEWAY</b> First Middle Last		4. DATE OF DEATH <b>FEB 19 1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1926</b>
9. AGE (In years last birthday) <b>32</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Distributor-B&amp;O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Brunswick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ralph Raymond Ridgeway</b>	
14. MOTHER'S MAIDEN NAME <b>Eula Belle</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO <b>W.W. II 220-18-325</b>	
17. INFORMANT <b>Mrs. Ralph Ridgeway</b>		Address <b>Brunswick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis (Stroke)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Feb 19, 1959</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>me</b> , 19 <b>58</b> , to <b>1959</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>19 Feb.</b> , 19 <b>59</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Howard E. Hall</b> M.D. <b>Sykesville, Md.</b> <b>19 Feb. 59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>A</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles F. Fester</b>		ADDRESS <b>Brunswick, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 24 59</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Hall</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01754

1750

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Mott Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mott Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALVER</u> Middle <u>EUGENE</u> Last <u>RUBY</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 30, 1881</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jesse Ruby</u>				14. MOTHER'S MAIDEN NAME <u>EMMELINE LEPPA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO <u>212-24-6078-M</u>			
17. INFORMANT <u>Alver E Ruby</u>				Address <u>HAMPSTEAD MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arterio-Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>1959</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>June 12, 1956</u> to <u>February 1, 1959</u> that I last saw the deceased alive on <u>January 31, 1959</u> and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>			
DATE SIGNED <u>2/1/59</u>							
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				<u>HAMPSTEAD Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Feb 4-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond A Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>O. E. &amp; H. H. H.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

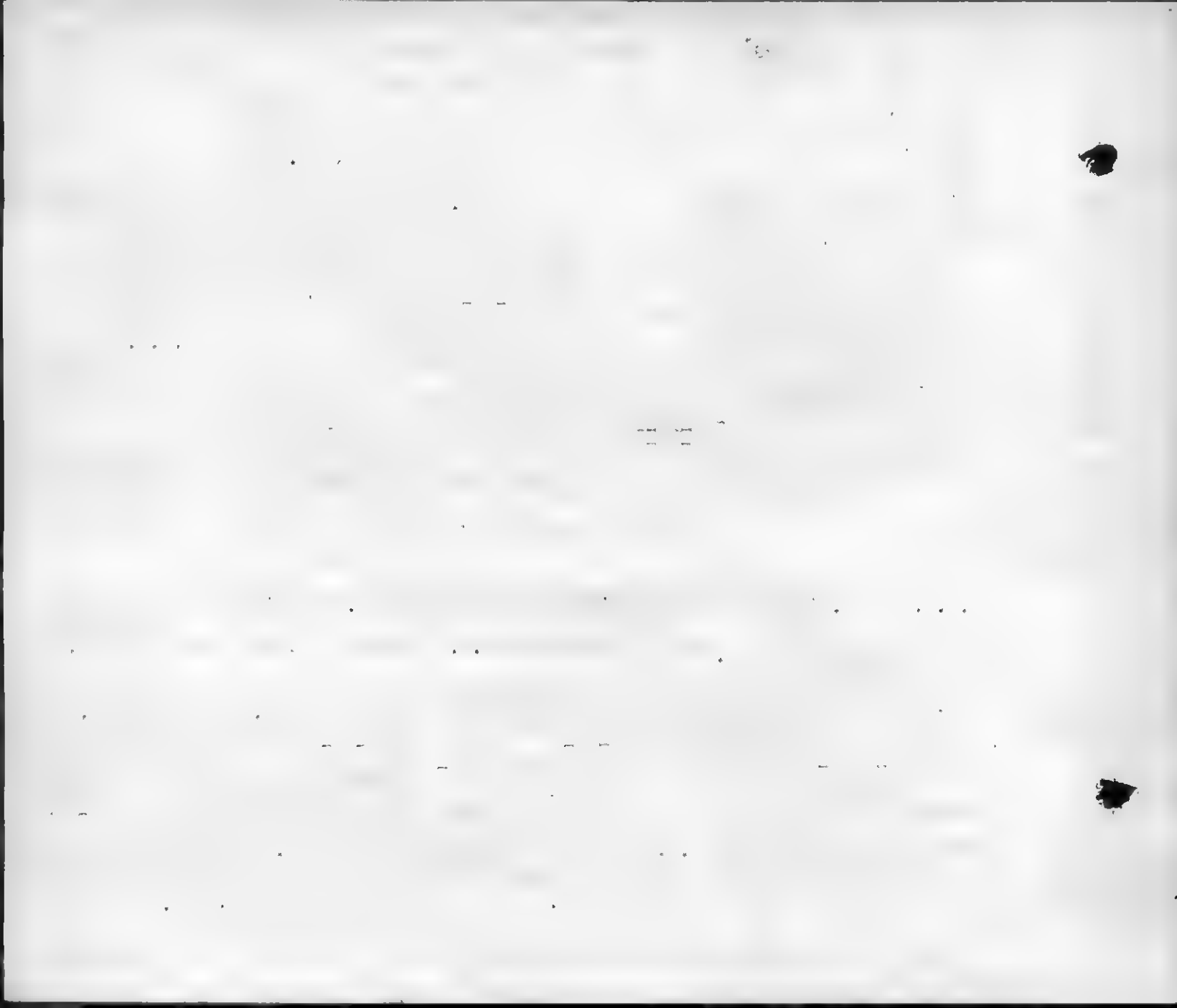
1751

## CERTIFICATE OF DEATH

Reg. Dist. No.

01755

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>9 m 10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>136 N. Ellwood Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>William</b> Middle <b>Schreiber</b> Last <b>Schreiber</b>		4. DATE OF DEATH		Month <b>2</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-79</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>79</b> Days <b>21</b> Hours <b>1959</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator operator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman Schreiber</b>				14. MOTHER'S MAIDEN NAME <b>Lena----</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO <b>218-001-0924</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>							<b>years</b>
DUE TO <b>Generalized arteriosclerosis</b>							<b>years</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (b) <b>C.B.S. assoc. with cerebral arteriosclerosis with psych. reaction</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, place, time, etc.) <b>pt. fell on the ward, P.M. was notified, released the body.</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:30 p.m. 12 18 58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital ward</b>	20f. (City or town) <b>Sykesville,</b>	(County) <b>Carroll</b>	(State) <b>Md</b>		
21. I certify that I attended the deceased from <b>5-12-</b> 19 <b>58</b> , to <b>2-21-</b> 19 <b>59</b> , that I last saw the deceased alive on <b>2-21-</b> 19 <b>59</b> , and that death occurred on <b>2-21-</b> 19 <b>59</b> at <b>9-30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
DATE SIGNED <b>2-22-59</b>							
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>							
<b>Sykesville, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>				ADDRESS <b>4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>EB 24 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

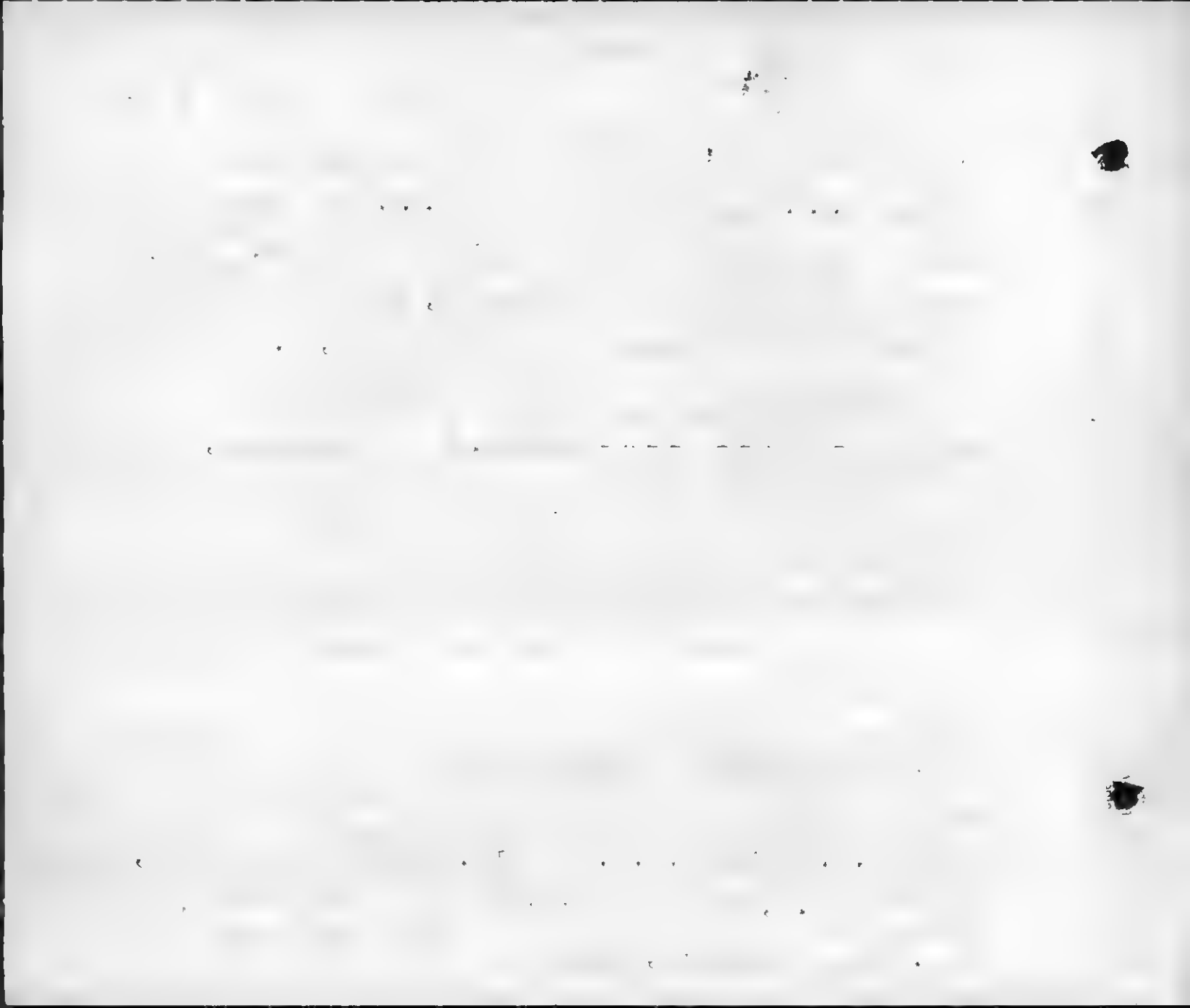
Reg. Dist. No.

01756

1752

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 4 Reese</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b>	
3 NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Kate</b> Last <b>Sies</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1863</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
10a. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Aaron Burgoon</b>		14. MOTHER'S MAIDEN NAME <b>Louise Hornberger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO -----	
17. INFORMANT <b>Howard I. Sies</b>		Address <b>Westminster, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular disease</b> DUE TO (c) <b>Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>ab. 10 years</b> <b>ab. 10 years</b> <b>ab. 15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 14</b> , 1930, to <b>2-15</b> , 1959, that I last saw the deceased alive on <b>2-14</b> , 1959, and that death occurred at <b>101</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 S. Center Street Westminster, Md.</b> DATE SIGNED <b>2-16-59</b>			
ACTUAL SIGNATURE <b>C. L. Billingslea</b> M.D.		DATE SIGNED <b>2-16-59</b>	
PHYSICIAN'S NAME (Type) <b>C. L. Billingslea, M. D.</b>		ADDRESS <b>1 S. Center Street Westminster, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 18, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>nr Westminster, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 18 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low **1752** that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1753

## CERTIFICATE OF DEATH

01757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Union Bridge</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Union Bridge</b>	
3. NAME OF DECEASED (Type or print) <b>Harriet V. Strausburg</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1878</b>
9. AGE (In years last birthday) <b>80 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Miller</b>		14. MOTHER'S MAIDEN NAME <b>Susan Foreman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Joseph P. Bostian, Middleburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-26-1959</b> to <b>2-28-1959</b> , that I last saw the deceased alive on <b>2-26-1959</b> and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Union Bridge 2-3-59</b>			
ACTUAL SIGNATURE <b>T.H. Legg, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Union Bridge, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Church of Christ Cem. Taneytown, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fusa &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orin L. Krawt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01758

1754

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R.D.2 (Union Mills)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b> d. STREET ADDRESS <b>Westminster, Md. R.D.2 (Union Mills)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Theodore David Utz</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George A. Utz</b>		14. MOTHER'S MAIDEN NAME <b>Savilla Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-4025</b>	
17. INFORMANT <b>Mrs. Theodore D. Utz, Westminster, Md. R.D.2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 27, 1959</b> to <b>Feb. 28, 1959</b> , that I last saw the deceased alive on <b>Feb. 27, 1959</b> , and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>12 W. King Littlestown, Pa</b> DATE SIGNED <b>2-28-59</b> ACTUAL SIGNATURE <b>L. L. Potter M.D.</b> PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D. 12 W. KING ST. LITTLESTOWN, PA</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 2 '59</b>	
ADDRESS <b>Littlestown, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Richard A. Little</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01759

1755

1. PLACE OF DEATH COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>19yrs8m.15d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Isadore</b> Middle <b>White</b> Last <b>White</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 31, 1898</b>	
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clothes mfg</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clothes manufact.</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Lewis White</b>				14. MOTHER'S MAIDEN NAME <b>Esther Goldman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>Records of the Springfield State Hospital</b>			
17. INFORMANT <b>Records of the Springfield State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>more than 5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with syphilitic meningoencephalitis; tabo-parosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 31, 1955</b> to <b>February 20, 1959</b> , that I last saw the deceased alive on <b>February 20, 1959</b> , and that death occurred at <b>7:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter Knopp</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital, 2 - 21 - 59</b>			
DATE SIGNED <b>2 - 21 - 59</b>							
PHYSICIAN'S NAME (Type) <b>Walter Knopp</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>2-22-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BNGRI / SRREL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc - 2100 Eutaw Pl.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. - 8 Knopp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>MASSACHUSETTS</u></p>	
<p>5. Date of death: <u>1975</u></p>		<p>6. Place of death: <u>MASSACHUSETTS</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1975</u></p>		<p>12. Office of registration: <u>MASSACHUSETTS</u></p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1756

1760

Reg. Dist. No.

1756

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY **Carroll** **MARYLAND**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Sykesville**

c. LENGTH OF STAY IN 1b **4 mos. 10 days**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Springfield State Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  
a. STATE **Maryland** b. COUNTY **Carroll**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Hampstead**

d. STREET ADDRESS **None**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First **Emma** Middle **Rill** Last **Wink**

4. DATE OF DEATH Month **February** Day **4** Year **19 59**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH **August 13, 1886** 9. AGE (In years last birthday) **72** yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Cement factory** 10b. KIND OF BUSINESS OR INDUSTRY **-** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Daniel Rill** 14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give war or dates of service) **-** 16. SOCIAL SECURITY NO. **219-14-9591** 17. INFORMANT Address **Springfield Hospital Records**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Infarction of myocardium due to coronary occlusion**  
DUE TO **420.1**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **420.1** DUE TO (c) **420.1**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.** 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. **19** 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **September 24, 19 58** to **February 4, 19 59**, that I last saw the deceased alive on **February 3, 19 59**, and that death occurred at **3:10A** M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Springfield State Hospital** DATE SIGNED **2/4/59**

ACTUAL SIGNATURE **Edmund Lusthaus** M.D. **Springfield State Hospital** **2/4/59**

PHYSICIAN'S NAME (Type) **Edmund Lusthaus, M.D.** **Sykesville, Maryland**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **2-7-1959** 22c. NAME OF CEMETERY OR CREMATORY **Hampstead** 22d. LOCATION (City, town, or county) (State) **Carroll Md**

23. FUNERAL DIRECTOR'S SIGNATURE **Edw. Chipton** ADDRESS **Hampstead Md** 24a. REC'D BY REGISTRAR DATE **FEB 6 '59** 24b. REGISTRAR'S SIGNATURE **Arthur L. Kraus**

